TASK FORCE TO STUDY THE DEVELOPMENTAL DISABILITIES ADMINISTRATION RATE PAYMENT SYSTEMS

JUNE 2008

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

June 1, 2008

The Honorable Martin O'Malley, Governor of the State of Maryland
The Honorable Thomas V. Mike Miller, President of the Senate
The Honorable Michael E. Busch, Speaker of the House of Delegates
The Honorable Members of the Senate Finance Committee
The Honorable Members of the Senate Budget and Taxation Committee
The Honorable Members of the House Health and Government Operations Committee
The Honorable Members of the House Appropriations Committee

Ladies and Gentlemen:

The Task Force to Study the Developmental Disabilities Administration Rate Payment Systems was created by Senate Bill 485 (Chapter 33 of the 2007 Laws of Maryland) and House Bill 1009 (Chapter 34 of the 2007 Laws of Maryland). The task force was directed to: 1) review the existing rate system for community-based services funded by the Developmental Disabilities Administration and determine its strengths and weaknesses; 2) identify current mandates for service delivery; 3) consider costs as reported in the Developmental Disabilities Administration cost report; 4) compare the cost of current mandates for service delivery to the level of funding provided by the State; 5) consider promising practices in rate systems in other states that fund appropriate and individual supports in a cost-effective manner, which are consistent with local and national best practices; 6) identify changes in the reimbursement system that further support self-directed services and implantation of best practices; and 7) develop recommendations to address the problem of the structural under-funding of community services.

The task force held seven meetings between October 12, 2007 and May 8, 2008. At these meetings the task force heard public testimony from advocates, consumers, providers, the State Board of Nursing, the Community Services Reimbursement Rate Commission (CSRRC) and a national expert on developmental disabilities payment systems. The task force discussed a myriad of issues including: the history of the fee payment system, Developmental Disabilities Administration (DDA) cost report data, information from other states reimbursement systems, assessment tools, waiting list information, transportation issues, nursing mandates, previous rate increases, add-on rates, self-directed services, Community Supported Living Arrangements (CSLA), supported employment (SE), and matrix levels.

This report describes the activities and recommendations of the Task Force to Study the Developmental Disabilities Rate Payment Systems.

Sincerely,

James P. Johnson
Chair

Task Force Members and Affiliations

Chair:
James Johnson, Deputy Secretary, Department of Health and Mental Hygiene

Members:
Audrey Waters, Deputy Director, Developmental Disabilities Administration
David Romans, Deputy Secretary, Department of Budget and Management
Mark Schulz, Maryland Association of Community Services
Vickie Mills, People on the Go
R. Colfax Schnorf, Jr., The ARC of Maryland
Theodore Giovanis, Community Services Reimbursement Rate Commission
Catherine Lyle, Developmental Disabilities Council
The Honorable Karen S. Montgomery, Maryland State House of Delegates
The Honorable Dolores G. Kelley, Maryland State Senate
Monica McCall, Creative Options, Inc.
Sandy Adkins, Somerset Community Services, Inc.
Tiye Mulazim, Shura
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Executive Summary

The Task Force to Study the Developmental Disabilities Administration Rate Payment Systems was created by Senate Bill 485 (Chapter 33 of the 2007 Laws of Maryland) and House Bill 1009 (Chapter 34 of the 2007 Laws of Maryland). The task force was directed to: 1) review the existing rate system for community-based services funded by the Developmental Disabilities Administration and determine its strengths and weaknesses; 2) identify current mandates for service delivery; 3) consider costs as reported in the Developmental Disabilities Administration cost report; 4) compare the cost of current mandates for service delivery to the level of funding provided by the State; 5) consider promising practices in rate systems in other states that fund appropriate and individual supports in a cost-effective manner, which are consistent with local and national best practices; 6) identify changes in the reimbursement system that further support self-directed services and implantation of best practices; and 7) develop recommendations to address the problem of the structural under-funding of community services.

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Findings and Recommendations

Cost reports and audited financial statements submitted by providers to the Developmental Disabilities Administration indicate that the financial condition of providers has worsened in recent years. This is measured by an increase in the number of providers reporting negative operating margins (expenses exceed revenues) and negative net assets (liabilities exceed assets), and a reduction in the average operating margins and current ratios. A report presented to the task force by the Community Services Reimbursement Rate Commission evaluating the operating margins of developmental disability providers by service category shows that the median margin for supported employment services is -4.43% and the median margin for day services is -2.67%. The information on provider financial status would indicate that adjustments to the rates paid for services to individuals with developmental disabilities are warranted.

After deliberation of the discussions and comments from the meetings, the task force endorses the following specific recommendations for changes to the Developmental Disabilities Administration rate system. Because the overall budget impact of these recommendations is considerable, and certain changes have a compounding effect, the

Developmental Disabilities Administration will need to act prudently in implementing these recommendations. Priority should be given to improving the rate system for supported employment and day services, which are the services with the greatest level of underfunding on recent cost reports.

The recommendations are as follows:

1. Assess consumers receiving DDA-funded services on a regular basis using reliable assessment tool.

2. Adjust the rates annually to account for changes in costs.

3. Revise matrix to add components that will replace add-ons to rates by accounting for those services within the matrix.

4. Adjust the administrative component of the rates to add costs for the nursing assessment and training. Further recommend that the Board of Nursing provide more guidance to the Developmental Disabilities Administration on ways to reduce the frequency of nursing assessments and training hours. Finally the task force encourages the Board of Nursing to work with the Developmental Disabilities Administration on future regulation and statute changes to include fiscal impact on providers.

5. Revise the calculation for the day services rates to change from a 7 day basis to a 5 day basis.

6. Phase-in rate system changes in a manner that does not reduce revenues for providers.

7. Inform community providers of the methodology for creating service hours in CSLA to allow providers to count hours provided to 2 or 3 individuals at the same time and place.

8. Inform community providers of exceptions to the attendance requirements for supported employment of 4 hours per day.

The task force recommends that the Developmental Disabilities Administration assemble a small workgroup to develop specific changes in the rate system.

Introduction

This report describes the activities and recommendations of the Task Force to Study the Developmental Disabilities Rate Payment Systems. The first part of the report summarizes the establishment of the task force. The second part describes the activities of the task force, including a discussion of the information gathered from various sources. The third part provides recommendations of the task force.

Establishment of the Task Force

The Task Force to Study the Developmental Disabilities Administration Rate Payment Systems was created by Senate Bill 485 (Chapter 33 of the 2007 Laws of Maryland) and House Bill 1009 (Chapter 34 of the 2007 Laws of Maryland) to examine issues related to the Developmental Disabilities Administration Rate Payment System. The Task Force was directed to examine:

> (1) Review the existing rate system for community–based services funded by the Developmental Disabilities Administration and determine its strengths and weaknesses;
>
> (2) Identify current mandates for service delivery;
>
> (3) Consider costs as reported in the Developmental Disabilities Administration's cost report;
>
> (4) Compare the cost of current mandates for service delivery to the level of funding provided by the State;
>
> (5) Identify promising practices in rate systems in other states that fund appropriate and individualized supports in a cost–effective manner, which are consistent with local and national best practices;
>
> (6) Identify changes in the reimbursement system that further support self–directed services and implementation of best practices; and
>
> (7) Develop recommendations to address the problem of the structural under–funding of community services.

The enabling legislation directed the task force consist of the following members:

- one member of the Senate of Maryland, appointed by the President of the Senate;
- one member of the House of Delegates, appointed by the Speaker of the House;
- the Secretary of Health and Mental Hygiene, or the Secretary's designee;
- the Secretary of Budget and Management, or the Secretary's designee;
- one representative from the Maryland Association of Community Services;
- one representative from the ARC of Maryland;

- one representative from People on the Go;
- four representatives of Developmental Disabilities Administration-funded community-based providers, including a provider of residential supports, a provider of supported employment supports, a provider of day habilitation services, and a provider of community-supported living arrangements;
- one representative from the Community Services Reimbursement Rate Commission;
- one individual familiar with rate systems for community services in Maryland and in other states; and
- one representative from the Developmental Disabilities Council.

The Secretary of Health and Mental Hygiene was charged with designating the chair of the task force from its membership. The Department of Health and Mental Hygiene was charged with providing staff for the task force.

Since all of the required appointments of members were not completed until September 2007, the task force was not able to schedule its first, organizational meeting until October 12, 2007. As a result, there was insufficient time for the task force to fulfill the work required under Chapters 33 and 34 before the date to report final findings and recommendations to the General Assembly (December 31, 2007). The Chairman wrote to the Governor, the President of the Maryland Senate and the Speaker of the House of Delegates to request an extension until June 2008.

Work of the Task Force

The 14-member task force met seven times between October 12, 2007 and May 8, 2008. At these meetings the task force heard public testimony from advocates, consumers, providers, the Board of Nursing, the Community Services Reimbursement Rate Commission (CSRRC), and a national expert on developmental disabilities payment systems. The issues discussed included the history of the fee payment system, cost reports and audited financial statements submitted to the Developmental Disabilities Administration (DDA), information from other states reimbursement systems, assessment tools, waiting list information, transportation issues, nursing mandates, previous rate increases, add-ons, self-directed services, Community Supported Living Arrangements (CSLA), Supported Employment (SE), and matrix levels. Table 1 provides a list of all of the issues set out by the legislature to be discussed and during which meeting they were discussed.

Table 1: Issue Areas Discussed by the Task Force							
	Meeting Date						
Issue as identified in Senate Bill 485/House Bill 1009	Oct 12	Dec 13	Jan 14	Feb 11	Mar 10	Apr 16	May 8
(1) Review the existing rate system for community–based services funded by the Developmental Disabilities Administration and determine its strengths and weaknesses;	✓	✓	✓	✓	✓	✓	✓
(2) Identify current mandates for service delivery;		✓	✓	✓			
(3) Consider costs as reported in the Developmental Disabilities Administration's cost report;		✓					✓
(4) Compare the cost of current mandates for service delivery to the level of funding provided by the State;			✓	✓			
(5) Identify Consider promising practices in rate systems in other states that fund appropriate and individualized supports in a cost–effective manner, which are consistent with local and national best practices;	✓		✓				
(6) Identify changes in the reimbursement system that further support self–directed services and implementation of best practices;			✓		✓		
(7) Develop recommendations to address the problem of the structural under–funding of community services						✓	✓

The complete meeting minutes are accessible at the task force web site at http://ddamaryland.org/taskforce.htm.

The following are summaries of the discussion had at each of the task force Meeting.

October 12, 2007 Meeting

The task force held its first meeting on October 12, 2007, at which organizational issues were discussed. Chairman James Johnson reviewed the purpose of the task force as defined by the enabling legislation[1] and led a discussion of minimum criteria to be considered in the rate setting system. The minimum criteria included:

- Rates must enable very individualized services, including a menu plan

[1] See Appendix #1

- Rates must be consumer centered and not push services toward congregate settings
- There must be standard rates that are equitable across all providers
- The rate system must be integrated into the DDA management information system (PCIS2) and allow for efficient federal billing
- There must be an objective method to determine the level of services for individuals

Members of the task force added other suggestions including building inflation into the system, available means to adjust rates when individuals needs change, a system for compensating service providers when an individual leaves a provider, adding geographic considerations to where consumer is being served. Delegate Montgomery pointed out that the management information system should not be the sole driver for changing rates nor should the programming of the computer system interfere with rate changes.

Audrey Waters, Acting Deputy Director of the Developmental Disabilities Administration, presented a history of rate-setting in the Developmental Disabilities Administration[2], aggregate cost report data from fiscal year 2007[3] and information on other states reimbursement systems for providing community services to people with developmentally disabilities[4].

The history of rate-setting in the Developmental Disabilities Administration began with the implementation of the Prospective Payment System (PPS). The PPS system had two rate components: a consumer or individual component based on individual need and a provider component based on administrative, general, capital and transportation costs. This system developed into a system of inequitable payments and the Developmental Disabilities Administration replaced PPS with the current Fee Payment System (FPS) in 1998. Under FPS the Developmental Disabilities Administration continues with two rate components, but the provider component is now a flat rate. Converting from PPS to FPS meant some providers gained revenue while other providers lost revenue. This conversion occurred over a three-year period (FY1998 – FY2000). FPS has now been extended to supported employment services. The FPS system is based on rates for congregate services with add-on components for services not reimbursed through the rate system. The Office of Health Care Quality reviews the level and quality of services provided.

Appendix 3 shows cost report information for FY 2006 by category of service: residential services, day services, supported employment and CSLA. The data shows that supported employment programs are losing money whereas CSLA programs are profitable. Residential and day services show modest losses in FY 2006. Transportation costs continue to play a large role in many of the programs. There was a request from task force members for information about profitability, capacity and movement from the waiting lists. This data will be provided at the next meeting. The issues with

[2] See Appendix #2
[3] See Appendix #3
[4] See Appendix #4

reimbursement that are preeminent include: transportation and nursing issues, staff development, dental reimbursement and caregiver interactions after consumer enters system.

Appendix 4 shows data on developmental disabilities rate reimbursement systems from other states. All states have a Medicaid Waiver to maximize use of federal funds to support community services.

To correct some of the funding problems in Maryland's developmental disabilities rate reimbursement system, task force members suggested that the current matrix system be updated with regular reassessments of individual needs, expansion of the matrix to accommodate add-on components, and regular inflationary increases in the rates. Members also expressed concern about the lack of fiscal notes for State Board of Nursing regulations that impact providers.

The following list of information was requested by the task force for review at the next meeting:

- Reports from Community Services Reimbursement Rate Commission web site
- Rate systems, per capita funding, and waiting lists from other states: AZ, VT, NH
- Budget increases for rates, wage initiative
- Copies of assessment tools
- # of utilization slots/services providing vs. vacancies
- # of individuals in other states per service type
- # served in MD per service type
- List of contacts
- Unfunded mandate discussion items

December 3, 2007 Meeting

The task force held its second meeting on December 3, 2007. Prior to the meeting information requested by task force members at the October 12 meeting was distributed.[5]

The Task Force discussed different assessment tools for determining level of services needed. Ms. Waters explained that assessments are performed by an independent agency. DDA uses a 5 x 5 matrix that uses a 5-point system to assess both health/medical needs and supervision/assistance needs. The current DDA residential model is based on a 3 person-per-house model. The matrix assessment is based on documentation received from multiple sources including medical professionals, education professionals and families. In 1997 a freeze was put on matrix levels indicating that an individual would have the same matrix score for as long as they were in the FPS system. Consequently, the matrix is completed upon entry of an individual into the system, but is not redone on a regular basis. Instead of updating the matrix add-on rates are used, which are completed at the regional offices. Providers present information on additional support needs for

[5] See Appendix #5

individuals and the regional office works with the provider and the consumer to determine level of need.

Extensive discussion occurred on the fact that as people age in the system, add-ons are the only recourse available to providers for the additional services required. The freeze on the matrix system and the inflexibility of the system in general places obstacles and barriers for serving consumers of advanced age or disability. The current payment system does not take into account inflation, increased needs, unfunded mandates such as nursing requirements and increased transportation costs. There were some questions about who pays for the requirement to follow more stringent physician orders.

There was an acknowledgment of the increased need for support as individuals receiving services progress. Questions were raised about whether an individual would need less support as they progress; if more frequent or systematic review of consumer's needs would be helpful; whether a new matrix/assessment tool is needed; and if the wage initiatives helped contend with inflationary increases. Members pointed out that different assessment tools could not only help with accurate payments but also could be used to look at outcome measures for consumers. The current Individual Indicator Rating Scale (IIRS) assessment tool does not allow for that.

The committee next reviewed the CSRRC reports that had comparisons between services provided and found that there was much variation among providers. The report also looked at workers and the differences in wages and turnover between providers. There were questions about regional commonalities and about the number of providers that are consistently in the margin of financial difficulty.

January 14, 2008 Meeting

The third meeting of the task force was held on January 14, 2008. The meeting included a report on reimbursement systems from Dr. Charles Moseley, National Association of State Directors of Developmental Disability Services.[6] Dr. Moseley's report included a review of promising practices in rate systems in other states that fund appropriate and individual supports in a cost-effective manner, which are consistent with local and national best practices. This report indicated the State of Vermont made a conscious decision to dedicate a portion of the funding each year to maintaining the existing provider network, with the balance dedicated to adding new placements. He described different types of resource allocation - prospective based on statistical data, retrospective based on a developmental model, and mixed. Dr. Moseley discussed the differing models used by several states. He also discussed the use of different assessment tools and the strengths and weaknesses of each. Dr. Moseley addressed the policy issues surrounding rate payment systems, including individual flexibility, adequate coverage of costs, self-direction, and cost containment.

Public testimony touched on the fact that Maryland has not rebased and that the payment system has not moved from the 3-bed model. Mr. Marty Lampner from The Chimes

[6] See Appendix #6

suggested that Maryland's rating pool is non-reliable and not valid, but that the use of a third party contractor (MAPS-MD) to perform matrix assessments has helped with reliability.

The issue of transportation services was also discussed at this meeting. Mr. Johnson discussed how assessment should include individual's needs specific to transportation. The providers on the task force pointed out that transportation is funded under the provider component of FPS, a flat rate system, which does not take into account differences in urbanization versus rural, nor does it encourage greater independence for consumers because it does not take into account transportation for social situations or weekend service. There are also differences in the type of transportation used (curb to curb, wheelchair lift vans, public transportation) and in the level of supervision needed when individuals are transported. The data on transportation is inconsistent, making it difficult to assess how to change the system to better serve individual needs. Public testimony highlighted the growing costs of transportation from gas increases to increases in maintenance of vehicles.[7] Transportation that is equipped to function for individuals with disabilities is costly to purchase and maintain. The reimbursement costs do not cover the costs of providing transportation when all the factors needed to provide transportation are factored in. Task force members discussed ways to improve reporting of transportation costs so that it is better understood on costs reports. A suggestion was made to segregate costs for gas, maintenance, vehicle purchase and staff.

February 11, 2008 Meeting

The fourth task force meeting was held on February 11, 2008. The first part of this meeting focused on the additional nursing requirements for providers. Senator Paula Hollinger, Pat Noble and Barbara Newman from the Board of Nursing spoke to the task force about nursing requirements. The requirements were set in the Code of Maryland Regulations (COMAR) in 1989 which charges nurses to assist Maryland citizens with developmental disabilities who are supported in community settings. In 1992 COMAR regulations were adopted that established the requirements for 45 days site visits so that nurses can be case managers. The Board of Nursing asserts that nurses are needed to conduct these site visits in order to check client prescription medication use, inspect tubes and monitor therapeutic and other effects. The nurses are there to coordinate care that is more complex. In response to a question from task force members, the panel indicated there is a need for oversight by nurses, because even in less complex cases some issues have occurred of expired over-the-counter drugs, and many of the more independent individuals with developmental disabilities are not as diligent in medication adherence and compliance. The medical technicians who support individuals on a regular basis are not trained to know the medications consumers are taking and the possible dangers.

Task force members raised issues with the process of certifying and training certified medical technicians. There was a 16 hours training program for DDA providers that started in March 2007. The training was initially taught by a LPN, but now must be taught by a RN, increasing training costs. The course itself was also increased from 16

[7] See Appendix #7

hours to 20 hours, making it impossible to be taught during 2 work days, increasing costs for shift coverage for workers and increasing overtime payments. Further, the requirement for individuals to have a health care provider instead of medical technician increases costs on the health care side for providers. The fiscal note that was attached to the proposed legislation was limited to the impact on the Board of Nursing but did not reflect the impact on the providers that have to deal with the results of the requirements.

In terms of licensing certified medical technician the members of the Board of Nursing pointed to the online renewal and the efforts they are making to make the process smoother and quicker. This system is making it easier to find and track applications. They are allowing people to work 60-90 days without certification following the initial training while completing the certifications process. The providers contend that the training of the certified medical technician takes money and time and they would like to know quicker if they cannot be certified so that they do not waste the time or money. The Board has made changes, such as not requiring background checks for renewals, in order to facilitate the process. The use of Human Resources Applicant Tracking (HRAT) can help providers categorize patients that need medical supervision as compared to those that just need someone to help with activities of daily living.

Public testimony by Laura Howell from the Maryland Association of Community Services (MACS) indicated that the rate system does not compensate for the additional nursing requirements or provider training[8]. In 2004 new regulations came out that said a LPN cannot conduct trainings or participate in the 45 day review process. The increased requirements for training hours and for nurses to do trainings put extra burdens on the providers and there was not adjustment for these costs in the rates. All these changes also put more demand on the delegating nurse. Testimony from Mr. Marty Lampner from The Chimes further reiterated the fact that the current rate system never contemplated paying for nursing services and with the graying of America, people in the system that need nursing services has increased tremendously since the regulations were written in 1986[9]. The nursing care plan can be expensive for provider and can be onerous on rural areas. Ms. Rosemarie Dejoiner, a nurse administrator, testified that unfunded nursing mandates with medications adherence and 45 day reviews are difficult to support and that a possible solution is to let the delegating nurse make recommendations about how often individuals should be seen.

Mr. Johnson and Ms. Waters provided a review of DDA budget data for previous rate increases, the value of add-ons and the comparison of rates and expansion in DDA.[10]

March 10, 2008 Meeting

The fifth task force meeting was held on March 10, 2008. The purpose of this meeting was to discuss the different programs/models that exist in the Developmental Disabilities

[8] See Appendix #8
[9] See Appendix #9
[10] See Appendix #10

Administration. Task force members discussed the strengths and challenges of each program. Many of the providers on the task force expressed concern about the level of funding for the supported employment program, indicating there was significant room for improvement in funding for this service. Ms. Lyle provided information to the task force making the case for increasing rates for employment services[11]. Other task force members concurred that over the years funding had been increased to put the program on equal financial footing with the day program, but that that was still not enough. One reason cited for the increased costs associated with the supported employment model is the one-on-one nature of this model, which increases administrative burden. With equal funding for supported employment and day services, there are no incentives for providers to provide supported employment services. Another major component of supported employment is transportation, and with the increases in gas prices it costs more because of the one-on-one nature of the program. Since there is no differentiation in the payment levels for supported employment and day services, concern was expressed about the lack of accurate data on how many people are doing supported employment and what industries/workplaces are employing workers with developmental disabilities.

An issue was raised about the cost differential for supported employment activities from the beginning stages of job development until employment begins. Providers responded that they do not get paid when they are looking for a job for a consumer, but they still have to hire someone to be a job coach and find the job. There is an issue for many individuals who are employed only part-time but still need transportation and supervision, which is not factored into the system. A suggestion was made about using grant funding to help support work coaches and facilitate the process of finding employment. Several providers questioned the use of this method as funding levels could be unstable and require greater administrative work. A comment was made that low payment rates leads to high turnover.

Public testimony was provided by Karen Lee from SEEC, who supported much of what was discussed by the task force members. Ms. Lee added that it is a matter of work force investment - the better we match individuals to proper work the less support they need, whereas the worst we match individuals to work the more support they need. She indicated that there is a problem with the financial model for supported employment and day services rates, as service days are divided by 7 days/week while services are actually only provided 5 days/week. Testimony was also given by Alliance about their inability to keep employment specialists because of the pay scale and increased case load. They also expressed problems with obtaining reimbursement for individuals working for ½ day supported or ½ day of day services, or for individuals that are not able to work 4 hours a day.[12]

There were public testimonies from Michael Bloom, Barbara Moore, and Ken Capone consumers who use self-direction about the benefits of self-directed services. These benefits included the ability to hire and fire staff. They identified problems with living arrangements for individuals in CSLA and FPS, who cannot live together if they have a

[11] See Appendix #11
[12] See Appendix #12

different funding stream. In self-direction people have greater independence. The New Direction waiver is a promising "best practice" that should be expanded. The testimonies all urged the task force to keep the funding in the waiver.[13]

Tim Wiens from Jubilee Association and Rick Callahan from Arc of Central Chesapeake gave public testimony on Community Supported Living Arrangements (CSLA) and the flexibility and independence this program allows individuals. If an individual does not like their CSLA provider they only have to change providers not housing, unlike in residential services in which if the individual does not like the provider they have to also find a new place to live. The problem with CSLA is the funding is insufficient to support market rate housing and a suggestion was made that DDA should adopt HUD housing guidelines housing rates. Testimony was also provided that CSLA rates should allow the flexibility of providing services to more than one individual at the same setting, and be reimbursed for both services, and that it is impossible to provide 30 hours of individual services and nursing service at the current payment level.[14]

April 16, 2008 Meeting

The sixth task force meeting was held on April 16, 2008. The purpose of this meeting was to discuss the matrix levels and draft recommendations for the final report.

There was a presentation by Mark Schulz[15] on matrix funding levels. The presentation demonstrated the difference between the amount providers spend on services to individuals and what is being paid by DDA. The analysis focused on the difference in the hourly wage supported in rates compared to what the providers spent. Driven by the State initiative to increase direct care wages, providers increased spending and wage levels. The DDA rates for wages did not keep pace with these changes. There was a question about provider fundraising filling the gap between what is provided and DDA payments. Many of the providers say that this is unrealistic, especially in these hard economic times. There was a suggestion about matching dollars from the county but Delegate Montgomery mentioned that those dollars will be increasingly unreliable. In addition to the difference noted above, the FPS rate also does not include overtime costs or leave/vacancy/holiday allowances. Many of the providers felt these costs should be built into the rates or given as an addition to the rates by DDA.

There was suggestion to eliminate some of the add-ons and put higher fringe benefit rates into the rate system to eliminate some of the problems with the rates. Ms. Waters explained that add-ons are negotiated on a case-by-case basis between the provider and the DDA regional offices. Funding is often dependent on resource allocations within DDA. Once approved, add-on rates are included in the DDA budget. There were questions about whether increasing the rates to eliminate add-ons would benefit all providers or result in reduced funding allowances for some.

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[13] See Appendix #13
[14] See Appendix #14
[15] See Appendix #15

There was discussion about wages for employees and the inability of providers to keep staff due to low wages, which in turn increases overtime and staff turnover. Providers are experiencing a 40% turnover rate. Questions were asked about the benefits that providers offer such as pensions and 403b plans. The direct care wage initiative encouraged these extra benefits, but providers did not offer the benefits at the percentages encouraged by DDA, opting instead to increase hourly wages. They offer retirement benefits after the 1st year so don't incur costs due to turnover within the first year of employment. Healthcare costs have increased 15% in recent years and the providers had to assume those costs. The fringe rate paid by providers for direct care workers is much closer to 27%, whereas the cost of fringe benefits for administrative positions average 20% due to the fact that they earn a higher wage and benefits are a smaller percent of their overall costs.

Residential services pose a problem because they need to have full time housing counselors and for individuals with awake overnight they need to provide one on one staff. Residential providers also have to deal with staffing issues for holiday and weekend relief, as well as transportation issues for appointments and social events during off-hours. These pressures, combined with inadequate inflation allowances in the FPS rate system, have reduced the flexibility of providers to deal with individual needs identified on the Individual Plan and have reduced consumer choice. Providers are working at a loss and dipping into reserves to stay afloat.

Mr. Adkins provided the task force with an analysis of the costs of 1-1 staffing and the inadequacy of the current rate methodology.[16] Vicki Callahan of Opportunity Builders offered public testimony in support of many of the issues discussed at the meeting.[17]

The task force had a discussion on the draft recommendations, including the core principles for the reimbursement system. There was some discussion on the principle of equitable payments. Dr. Lovell wanted to ensure that principle meant that providers in higher cost areas of the State, such as Montgomery County, continue to get rates that contain regional adjustments. The suggestion was made to add language to that principle to clarify if geographical differences in payments should continue.

Rather than design a new rate system, the consensus of the task force was to make changes to the current system. In considering detailed changes to the DDA rate system, there was a suggestion to form a work group to deal with issues with the funding levels in the matrix.

Mr. Johnson led a discussion about the funding history for DDA. Changes were made to tables in response to members' comments that the original tables were confusing. The revised tables show changes based on expansion and not overall budget. Ms. Lyle suggests that what is missing from this section is the purpose of the task force and the problem that we are trying to address. Perhaps what might best illustrate the point of the purpose and need for the task force is charts that show data trends over time of how

[16] See Appendix #16
[17] See Appendix #17

providers are faring, such as the number of providers that are experiencing operating deficits. Mr. Giovanis offered to provide information at the next task force meeting on provider financial status for the past 6-7 years. This information will also show the relative profitability of day, supported employment, CSLA and residential services by provider. This background information, together with the DDA funding history, will give a better picture of the overall financial situation for providers. Preliminary results indicate that providers are experiencing a worsening fiscal situation in recent years.

There was discussion about including language in the final report that indicates that budget constraints may limit funding to address both expansion of services to individuals with developmental disabilities and improvements in the rates. Some task force members felt that it was not the job of the task force to address this budget issue and that it was somehow giving the State reason not to deal with inadequate funding for rates. Mr. Giovanis pointed out that every year the Community Services Reimbursement Rate Commission has recommend increases in provider rates and it has only been granted twice. He suggested including a paragraph in the report about specific policy choices. Mr. Schulz sees this statement as an opportunity to say we have to plan better for providing for DD services given current and future budget constraints.

A question was raised about comparing DDA and other DHMH agencies, such as MHA. In other agencies are the funds being used for expansion or increases in rates? How do these agencies compare in the percentage increase they get for inflation and wages? Mr. Johnson indicated that in Medicaid most funding goes towards adjusting rates for existing programs and not toward expansion. Examples include increases for the hospitals, nursing homes and MCOs for inflation adjustments. By comparison, the increase in DDA is used more heavily towards expansion of services and not for inflation adjustments.

Mr. Johnson asked about changing the assessment tool and indicated that he did not get the sense from earlier discussions that that is something the task force wants to address. Task force members indicated that changing the assessment tool would require changing the matrix system, which would be a monumental task that would require large-scale system changes. There is the belief among some members of the task force that there is no need to change the assessment tool. If new funding is not added to the DDA rates it may be best to follow Arizona's example of setting a standard within the current system and work towards funding that benchmark. It was pointed out that we are considering an item in which we spend $2.5 million on and it may be worth it to look and see if the State is using the right assessment tool. In response, a suggestion was made that instead of changing the assessment for all individuals that we change the assessments for a smaller sample of individuals on a pilot basis.

May 8, 2008 Meeting

The seventh task force meeting was held on May 8, 2008. The purpose of this meeting was to discuss the financial status of providers and the recommendations for the final report.

Graham Atkinson, D.Phil, who provides staff assistance to the Community Services Reimbursement Rate Commission, presented information on the most recent cost reports and audited financial statements from community services providers[18]. The presentation highlighted the report data from 110 audited financial statements and DDA cost reports, which were used to investigate provider fiscal status. The report focused on the median levels for the providers, as this discounted outliers – providers with unusually high or low reports. The report found:

- in 2007 34% of providers have negative operating margins
- since 2000-2005 the financial measures for providers improved, but that trend reversed itself in 2006 with mixed results, and in 2007 with all of the five financial factors
- median margins for supported employment and day services have been losses in 2006-2007, and the median margin for residential services shows a modest loss in 2007; only CSLA reports a surplus in both 2006 and 2007

In conclusion the overall condition of providers shows deterioration. The financial status of providers is not good and is declining with Supported Employment (SE) being of most concern.

Delegate Montgomery expressed concern about the losses in supported employment that may be an incentive for providers to cut employment programs and put people back in workshops. Mr. Romans asked what a reasonable operating margin would be, and Dr. Atkinson commented that in the hospital system the expectation is that hospitals consistently make 3-5% profit each year. He also commented that it is not a healthy situation for 34% of providers to be losing money. Another question was raised about commonalities among providers and services losing money. Dr. Atkinson replied that CSRRC looked at finances by region and there was not a disproportionate number in any one region, but they had not looked at it by service. Mr. Giovanis pointed out the commission asked Dr. Atkinson to look at everything in total and that they did not look at individual providers, as that is the role of DDA. The CSRRC role is to look at it on a macro level and systemic level.

Next the task force reviewed the recommendations for the final report. At the outset, feedback was received on grammar and factual corrections in the draft report. Ms Lyle suggested that the task force include some language on transitioning youth programs because these are the first to be cut in the legislature. Delegate Montgomery suggests tying the concept of these transitioning youth programs and supported employment into the larger workforce development movement.

[18] See Appendix #18

Mr. Johnson noted that after today's presentation by Dr. Atkinson, some changes to the tables on the financial condition of providers would be made to reflect the median number, which is a better indicator. A suggestion was made to clarify language describing these tables to indicate that despite the emphasis on funding increases for expansion of services in DDA, prior funding levels have not been sufficient to meet the demand, as evidenced by the large waiting list. Mr. Schnorf raised concerns about the sentence that talks about the state revenue growth and suggested that DDA budgets have not increased by double the rate of State revenue growth. Mr. Johnson offered to look into getting the actual state growth percentages and modifying that statement accordingly.

Mr. Johnson provided the task force members with a letter from Dr. Lovell[19] requesting alternate wording to the core principle dealing with equitable rates. Following a discussion about the proposed language, which sought to expand on the definition of equitable rates to include geographic and programmatic differences, the task force members chose not to adopt the proposed language.

The issue of changing the assessment tool was discussed. The consensus of task force members was that the assessment tool should not be changed unless the funding was going to change. It was suggested that consideration of a change in the assessment tool should be included in a strategic plan for DDA. Mr. Johnson pointed out that draft recommendation #1 dealt with reassessing individuals more often to determine changes to their needs, as measured by their matrix levels. This recommendation is costly, with an estimated cost of $2.6 million per year to reassess every individual on a four-year cycle. Concern was expressed about limiting the reassessments to once every four years, as some consumers need more frequent reassessment and others need less frequent reassessment. It was generally agreed that assessments should account for major changes in an individual's status, such as a major medical event. However, it is unlikely that providers would request a reassessment if the individual's needs lessen. Providers on the task force expressed doubts that needs would lessen over time. In order to provide a benchmark to judge the value of reassessing all individuals receiving services, it was suggested that a pilot program of a randomly selected group of individuals be reassessed in addition to those self-selected by the provider. DDA needs to ensure that the assessments from the pilot program and the self-selected pool are representative of all providers and consumers at different levels of need. Finally, a proposal was made to use objective language, such as documented change in skill level, behavior or medical condition, to warrant a reassessment.

For draft recommendation #2, which recommends updating rates annually, Delegate Montgomery suggested the words "reasonable increases" are ambiguous. The task force members agreed to change "reasonable increases" to "changes". Mr. Romans suggested that the task force consider allowing DDA to take back funds from providers that are above a certain profit margin and redirect the funds to those not doing so well, as is the practice in other State programs. There was concern from members that this would penalize providers that are efficient or that have successful fundraising activities in a given year.

[19] Appendix #19

Draft recommendation #3 replaces add-on rates with changes to the matrix. Mr. Johnson pointed out that this was a budget neutral proposal and should reduce administrative costs for both providers and the State. Mr. Schulz suggests that for some people the variations in what they need are so different that one flat level will not fit, so the recommendation should not completely eliminate add-on rates.

Draft recommendation #4 deals with nursing issues. There were several suggested changes to the wording, especially concerning the authority of the task force to direct Board of Nursing actions. It was agreed that the task force would recommend that the Board of Nursing provide guidance to DDA on ways to limit nursing requirements. It was also agreed that this recommendation is not budget neutral, as DDA rates have not been increased in the past to reflect these mandated services. The task force members also expressed concerns about informing the legislature about funding needs when mandates are added through legislation or regulation. Representatives from the Board of Nursing questioned the basis for the recommendation, but subsequently provided clarification that regulation changes in 2004 and 2005 required that 45 day site visits be performed by registered nurses and that training programs be increased from 16 hours to 20 hours.

Draft recommendation #5 recommends revising the calculation of day and supported employment rates from 7-days/week to 5-days/week. This change would increase the funding levels dramatically. Consequently, it was recommended that the rate levels be adjusted to avoid creating a large surplus in these programs.

The task force members agreed that phasing in rate system changes in a way that is intended to avoid creating "winners and losers", as proposed in draft Recommendation #6, was appropriate. There was a discussion about CSLA programs, which are experiencing positive operating margins (median margin 9.33% in FY07), although DDA audits are taking funds back as a result of audit disallowances. Any changes in future rates needs to account for these audit disallowances.

The task force was supportive of recommendations #7 and #8, which do not change DDA policy, but request that DDA inform providers about nuances in the rate system.

There were several general comments, including comments about congruity between the executive summary and the recommendations, and the lack of coverage in the final report/recommendations for programs such as New Directions waiver and residential. A discussion ensued about the costs of room and board for residential providers, with a recommendation to direct that future SSI increases be used to offset increases in room and board costs. This recommendation was not adopted by the task force.

Mr. Johnson suggested another recommendation be added for DDA to develop a small work group to look at the specific changes in matrix levels. The task force members concurred.

Laura Howell from MACS provided public comments on measurement of provided services and establishing a benchmark of reasonable costs to provide services. She also suggested the task force acknowledge that cost reports reflect what people feel they can spend, and that the task force focused their recommendations on supported employment and not did not address residential services.

Findings and Recommendations of the Task Force

Cost reports and audited financial statements submitted by providers to the Developmental Disabilities Administration indicate that the financial condition of providers has worsened in recent years. The Community Services Reimbursement Rate Commission uses the information submitted to DDA to evaluate the financial condition of providers. This is measured by the number of providers reporting negative operating margins (expenses exceed revenues) and negative net assets (liabilities exceed assets), and a review of median operating margins (revenues over expenses), median current ratios (current assets over current liabilities), and the percentage of providers with a current ratio less than 1 (current liabilities exceed current assets). Median margins and median current ratios are used, rather than a simple average (the mean), as the median excludes the effects of outliers of unusually high or low costs. Table 2 shows information from the Community Services Reimbursement Rate Commission summarizing provider financial status from FY 1999-2007 cost reports and audited financial statements. For 2007, all of the measures used to evaluate provider financial status would indicate that adjustments to the rates paid for services to individuals with developmental disabilities are warranted.

Table 2	FY99	FY00	FY01	FY02	FY03	FY04	FY05	FY06	FY07
% with negative margins	20%	25%	43%	32%	22%	29%	23%	29%	34%
Median margin	3.1%	3.2%	0.7%	1.3%	2.5%	1.6%	2.3%	2.3%	1.6%
Median current ratio	1.9	1.4	1.8	1.7	1.8	1.7	1.7	1.4	1.4
Number with negative net assets	3	2	7	3	3	6	5	5	9
% with current ratio < 1	23%	26%	31%	28%	20%	24%	27%	27%	30%

The Community Services Reimbursement Rate Commission also provided information evaluating the operating margins of developmental disability providers by service category. This information shows that the median margin for supported employment services has expenses that consistently exceed revenues, and the median margin for day services shows increased losses in the most recent year. Residential services have also shown losses in recent years, while CSLA services are operating with robust operating margins. Although CSLA services are doing well in recent years, the revenues

attributable to CSLA are small compared to other services showing losses and recently the DDA has indicated that the CSLA service margins could be reduced due to the result of audits. Table 3 shows the median operating margin for each service as a percentage of revenues.

Table 3	Residential	Day	SE	CSLA
FY06 Median Margin	0.54	-0.20	-5.20	9.33
FY07 Median Margin	-0.97	-2.67	-4.43	7.65
% of Revenue	61	19	11	9

Table 4 shows the breakdown of the total funding increase in the community services budget for fiscal year 2000 until 2008. The annual budget increase for community services ranged from 7% to 12%, significantly higher than the growth in State revenues.

Table 4	Community Services Budget Increase	Overall % Change
FY00	31,583,484	10.3%
FY01	24,970,371	7.4%
FY02	33,519,543	9.2%
FY03	46,654,838	11.8%
FY04	30,922,226	7.0%
FY05	42,520,131	9.0%
FY06	37,967,358	7.3%
FY07	46,241,729	8.3%
FY08	47,865,419	8.0%

Table 5 shows the breakdown of the amounts of funding increases in DDA community services for expansion of services, annualization and rebasing of existing commitments, COLAs, wage increases and other inflation adjustments. This information shows that funding increases for expansion of services, annualization and rebasing have been more consistent than funding increases for COLA, wages and inflation. Excluding the direct care wage initiative, in 4 of the past 9 years there has been no inflation allowance for community programs, in two years the inflation allowance was $1.5 million, and in the other 3 years the inflation has been $6-$12 million. In comparison, the increases for service expansion and annualization have consistently been $20-$30 million each year. It should be noted that despite these increases in services, the waiting list for individuals with developmental disabilities seeking services through DDA continues to grow.

Table 5	Service Expansion	Annualization/ Rebasing	Wage Initiative Increase	Inflation/Rate Increase	Inflation/Wage % Change
FY00	11,609,913	18,473,571	0	1,500,000	0.5%
FY01	12,208,872	6,072,905	0	6,688,594	2.1%
FY02	11,951,019	10,792,874	0	10,775,650	3.1%
FY03	12,241,067	16,743,097	16,170,674	1,500,000	4.7%
FY04	12,362,958	4,005,661	14,553,607	0	3.5%
FY05	13,592,198	11,140,192	17,787,741	0	4.0%
FY06	9,997,196	11,730,587	16,239,575	0	3.3%
FY07	23,786,334	6,215,820	16,239,575	0	3.1%
FY08	12,633,352	21,440,758	0	12,036,923	2.1%

The information from Tables 2-5 are somewhat contradictory, but might indicate a need for greater prioritization of funding for base programs and inflation in order to maintain a strong, viable provider network.

In changing the rate system to adequately compensate providers for the services they render to individuals with developmental disabilities, the task force members agree that the rate reimbursement system must include the following core principles:

- Rate system must support consumer driven choice
- Rates must be equitable across all providers
- There must be an objective method to determine the levels of services needed by each individual
- Rates must be adequately funded, with regular inflation adjustments
- Rates must be adjusted to reflect the changing needs of individuals

After deliberation of the testimony, discussions and comments from the meetings, the task force endorses several specific recommendations for changes to the Developmental Disabilities Administration rate system. Because the overall budget impact of these recommendations is considerable, and certain changes have a compounding effect, the Developmental Disabilities Administration will need to act prudently in implementing these recommendations. Priority should be given to improving the rate system for supported employment and day services, which are the services with the greatest level of underfunding based upon recent cost reports.

The recommendations of the task force are as follows:

1. **Assess consumers receiving DDA-funded services on a regular basis using a reliable assessment tool.**
   The Task Force had much discussion about the changing needs of individuals served in community programs, especially noting differences in services needed due to the aging of the DDA population. The current rate setting process freezes the payment level based on the initial assessment, which does not allow for adjusting the reimbursement based on changes in the individual's needs. This recommendation would institute an assessment of individuals with a documented change in skill level,

behavior or medical condition, in order that the reimbursement system recognize the changing needs of the population. Further, in order to assess if more comprehensive assessments of all individuals is needed, DDA should assess a random sampling of individuals each year. There would be a cost of approximately $1 million to conduct 2,500 assessments, and there is likely to be an increase in rates to reflect the changing needs of the population, although the amount is indeterminate. The costs of the assessments and the subsequent increase in rates are not specifically included in the current DDA budget. DDA may consider adopting a new assessment tool, especially for new services funded through rates or for new waiver services. The adoption of a new assessment tool should not be implemented in a way that reduces revenues from the current rate system.

2. **Update the rates annually to account for changes in costs.**
The Task Force also heard testimony from many sources about the need to provide inflation adjustments annually. While the wage initiative provided substantial increases in funding for direct care wages and fringe benefits, no funding allowances were made for costs of utilities, food, insurance, vehicles, dental services and other routine operating costs during that period. Subsequent "COLA" adjustments have been deemed inadequate to address routine operating costs (utilities, food, insurance, vehicles, dental services, etc.), leaving no funding for salary and fringe benefit increases. Future rate updates must address both salary and non-salary items to portray actual cost of operations for community providers, as recommended by the Community Services Reimbursement Rate Commission. It is recommended that the cost reports submitted to DDA be used to compile a "market-basket" of provider costs that can be used to develop weights for proportions of input costs which could be used for the update adjustment.

3. **Revise matrix to add components that will replace add-ons to rates by accounting for those services within the matrix.**
The matrix provides reimbursement rates for certain needs, but add-on rates are sometimes needed to address costs, such as awake overnight supervision, that exceed the matrix schedule. Add-ons must be requested by the provider and approved at the discretion of the DDA. In FY08, 26% of billed services have an add-on rate, which increases billing by requiring more information from the provider and more review on the part of the DDA. Expanding the matrix to eliminate or reduce add-ons will result in administrative efficiencies for both providers and State/DDA, as reimbursement can be handled through the existing rate system in an objective manner. Expanding the matrix will allow new matrix scores that incorporate some aspects of the add-ons to be funded as part of the rate reimbursement process. DDA should establish rates to make implementation of this action budget neutral. The add-on rates for certain services may still need to continue as those services may not lend themselves to the matrix.

4. **Adjust the administrative component of the rates to add costs for the nursing assessment and training. Further recommend that the Board of Nursing provide guidance to the Developmental Disabilities Administration on ways to reduce the frequency of nursing assessments and training hours. Finally the task force encourages the Board of Nursing to work with the Developmental Disabilities Administration on future regulation and statute changes to include the fiscal impact on providers.**
   The Board of Nursing requirement for frequent assessment of consumers by nursing professionals has resulted in an unfunded mandate for providers, increasing nursing costs and increasing costs for training nursing employees, without a commensurate increase in rates. The task force recommends that an allowance be included in the administrative component of the rates for nursing assessments and training. The task force also recommends the Board of Nursing provide guidance to the Developmental Disabilities Administration on ways to reduce the frequency of nursing assessments and training hours for providers of developmentally disabled services without decreasing quality of care and include such in the Board of Nursing requirements. Finally, the task force noted that prior regulation changes by the Board of Nursing did not include the fiscal impact on providers. The task force encourages the Board of Nursing to work with the Developmental Disabilities Administration on future regulation and statute changes to include fiscal impact on providers.

5. **Revise the calculation for the day services rates to change from a 7-day basis to a 5-day basis.**
   Currently the rates being paid to providers of day services are based on seven days of service per week. Because these services are offered only five days per week, a provider will only get 5/7 of the payment. Providers assert that this calculation is causing them to be underfunded. According to an analysis done by DHMH this change would have resulted in an increase in payments in FY06 of approximately $14.6 million in day services and $8.2 million in supported employment.to the DDA budget. However, the FY06 costs report indicates losses of $7 million for supported employment and a break-even situation for day services. Changes are merited in the rates but adjustments must be made to ensure that services are not over-funded.

6. **Phase-in rate system changes in a manner that does not reduce revenues for providers.**
   The task force recommends that any changes not be implemented in a way that is intended to reduce funds for certain providers in order to fund increases for other providers. Rather than creating "winners and losers", changes in rates should be phased-in over time, gradually implementing enhancements to the rate system.

7. **Inform community providers of the methodology for creating service hours in CSLA to allow providers to count hours provided to 2 or 3 individuals at the same time and place.**
   For providers that have residents that include 2 or more people, services can be provided to more than one individual at the same time. Some providers were under

the impression that they could only bill for 2 hours. It is efficient to provide services to more then one individual at the same time and is presently allowed within the DDA rate system. Currently providers can bill for each individual served as compared to the aggregate hours served in the residence.

8. **Inform community providers of exceptions to the attendance requirements for supported employment of 4 hours per day.**
   DDA regulations generally require that individuals engage in 4 hours of supported employment per day before a provider can receive reimbursement, but exceptions may be granted. Testimony indicated that several providers were not aware of the exception to this requirement. DDA regulations state that as long as the Individual Plan (IP) stipulates the individual cannot engage in 4 hours of program activities then a provider can be reimbursed for a full attendance day if the individual works less than 4 hours. There is some flexibility in the system that allows exceptions so that providers can bill for those hours spent in supported employment to day or ISS systems.

Finally, adopting specific changes to the DDA rate system will involve lengthy, detailed review of data. It is the recommendation of the task force that Developmental Disabilities Administration involve a small workgroup to conduct the reviews and develop specific changes in the rate system.

Appendices

CHAPTER 33

(Senate Bill 485)

AN ACT concerning

Task Force ~~on the Structural Under-Funding of Community Services for Individuals with Developmental Disabilities~~ to Study the Developmental Disabilities Administration Rate Payment Systems

FOR the purpose of ~~establishing the Task Force on the Structural Under-Funding of Community Services for Individuals with Disabilities~~ requiring the Department of Health and Mental Hygiene to establish the Task Force to Study the Developmental Disabilities Administration Rate Payment Systems; providing for the membership of the Task Force; requiring the ~~Task Force to elect~~ Secretary of Health and Mental Hygiene to appoint a chair; requiring the Department of Health and Mental Hygiene to provide staff for the Task Force; providing for the duties of the Task Force; prohibiting members of the Task Force from receiving certain compensation; authorizing members of the Task Force to receive certain assistance upon approval of the Secretary of Health and Mental Hygiene; requiring the Task Force to report to the Governor, the Senate Finance Committee, the Senate Budget and Taxation Committee, the House Health and Government Operations Committee, and the House Appropriations Committee; providing for the termination of this Act; and generally relating to the Task Force ~~on the Structural Under-Funding of Community Services for Individuals with Disabilities~~ to Study the Developmental Disabilities Administration Rate Payment Systems.

Preamble

WHEREAS, Community services for individuals with developmental disabilities should be high quality and individualized to meet each person's needs; and

WHEREAS, 22,000 individuals with developmental disabilities, with over 16,000 more on the Waiting List, depend upon the community services funded by the State of Maryland; and

WHEREAS, The viability of community services for individuals with developmental disabilities is threatened by structural under–funding; and

WHEREAS, Maryland ranks 44th nationally in its fiscal effort to fund and support services for individuals with developmental disabilities; and

WHEREAS, National best practices in community–based supports include self–directed services and customized employment; and

WHEREAS, Without a timely solution to the structural under–funding, State–funded community–based providers will be unable to continue to provide quality services that are accessible throughout Maryland; now, therefore,

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That:

(a) ~~There is a Task Force on the Structural Under–Funding of Community Services for Individuals with Developmental Disabilities~~ The Department of Health and Mental Hygiene shall establish a Task Force to Study the Developmental Disabilities Administration Rate Payment Systems.

(b) The Task Force ~~consists~~ shall consist of the following members:

(1) One member of the Senate of Maryland, appointed by the President of the Senate;

(2) One member of the House of Delegates, appointed by the Speaker of the House;

(3) The Secretary of Health and Mental Hygiene, or the Secretary's designee;

(4) The Secretary of Budget and Management, or the Secretary's designee;

(5) One representative from the Maryland Association of Community Services;

(6) One representative from the ARC of Maryland;

(7) One representative from People on the Go;

(8) Four representatives of Developmental Disabilities Administration–funded community–based providers, including a provider of

residential supports, a provider of supported employment supports, a provider of day habilitation services, and a provider of community–supported living arrangements;

(9) One representative from the Community Services Reimbursement Rate Commission; ~~and~~

(10) ~~One individual with expertise on rate systems for community services in other states~~ One individual familiar with rate systems for community services in Maryland and in other states; and

(11) One representative from the Developmental Disabilities Council.

(c) The Secretary of Health and Mental Hygiene shall appoint the nondesignated members of the Task Force.

(d) The ~~Task Force members shall elect a chair~~ Secretary of Health and Mental Hygiene shall appoint the chair of the Task Force from its membership.

(e) The Department of Health and Mental Hygiene shall provide staff for the Task Force.

(f) A member of the Task Force may not receive compensation as a member of the Task Force but is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(g) On approval of the Secretary of Health and Mental Hygiene, the Department shall provide assistance to members requiring additional services to attend meetings of the Task Force.

(h) The Task Force shall:

(1) Review the existing rate system for community–based services funded by the Developmental Disabilities Administration and determine its strengths and weaknesses;

(2) Identify current mandates for service delivery;

(3) Consider costs as reported in the Developmental Disabilities Administration's cost report;

~~(3)~~ (4) Compare the cost of current mandates for service delivery to the level of funding provided by the State;

~~(4)~~ (5) ~~Identify~~ Consider promising practices in rate systems in other states that fund appropriate and individualized supports in a cost–effective manner, which are consistent with local and national best practices;

~~(5)~~ (6) Identify changes in the reimbursement system that further support self–directed services and implementation of best practices; and

~~(6)~~ (7) Develop recommendations to address the problem of the structural under–funding of community services.

(i) The Task Force shall report its findings and recommendations by December 31, 2007, to the Governor, and, in accordance with § 2–1246 of the State Government Article, the Senate Finance Committee, the Senate Budget and Taxation Committee, the House Health and Government Operations Committee, and the House Appropriations Committee.

(j) After the Task Force has submitted its final report, the Task Force shall continue to advise the Governor and the Maryland General Assembly on the implementation of its recommendations.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2007. It shall remain effective for a period of 1 year and 1 month and, at the end of July 31, 2008, with no further action required by the General Assembly, this Act shall be abrogated and of no further force and effect.

Approved by the Governor, April 10, 2007.

CHAPTER 34

(House Bill 1009)

AN ACT concerning

Task Force ~~on the Structural Under–Funding of Community Services for Individuals with Developmental Disabilities~~ to Study the Developmental Disabilities Administration Rate Payment Systems

FOR the purpose of ~~establishing the Task Force on the Structural Under–Funding of Community Services for Individuals with Disabilities~~ requiring the Department of Health and Mental Hygiene to establish the Task Force to Study the Developmental Disabilities Administration Rate Payment Systems; providing for the membership of the Task Force; requiring the ~~Task Force to elect~~ Secretary of Health and Mental Hygiene to appoint a chair; requiring the Department of Health and Mental Hygiene to provide staff for the Task Force; providing for the duties of the Task Force; prohibiting members of the Task Force from receiving certain compensation; authorizing members of the Task Force to receive certain assistance upon approval of the Secretary of Health and Mental Hygiene; requiring the Task Force to report to the Governor, the Senate Finance Committee, the Senate Budget and Taxation Committee, the House Health and Government Operations Committee, and the House Appropriations Committee; providing for the termination of this Act; and generally relating to the Task Force ~~on the Structural Under–Funding of Community Services for Individuals with Disabilities~~ to Study the Developmental Disabilities Administration Rate Payment Systems.

Preamble

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WHEREAS, 22,000 individuals with developmental disabilities, with over 16,000 more on the Waiting List, depend upon the community services funded by the State of Maryland; and

WHEREAS, The viability of community services for individuals with developmental disabilities is threatened by structural under–funding; and

WHEREAS, Maryland ranks 44th nationally in its fiscal effort to fund and support services for individuals with developmental disabilities; and

WHEREAS, National best practices in community–based supports include self–directed services and customized employment; and

WHEREAS, Without a timely solution to the structural under–funding, State–funded community–based providers will be unable to continue to provide quality services that are accessible throughout Maryland; now, therefore,

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That:

(a) ~~There is a Task Force on the Structural Under–Funding of Community Services for Individuals with Developmental Disabilities~~ The Department of Health and Mental Hygiene shall establish a Task Force to Study the Developmental Disabilities Administration Rate Payment Systems.

(b) The Task Force ~~consists~~ shall consist of the following members:

(1) One member of the Senate of Maryland, appointed by the President of the Senate;

(2) One member of the House of Delegates, appointed by the Speaker of the House;

(3) The Secretary of Health and Mental Hygiene, or the Secretary's designee;

(4) The Secretary of Budget and Management, or the Secretary's designee;

(5) One representative from the Maryland Association of Community Services;

(6) One representative from the ARC of Maryland;

(7) One representative from People on the Go;

(8) Four representatives of Developmental Disabilities Administration–funded community–based providers, including a provider of

residential supports, a provider of supported employment supports, a provider of day habilitation services, and a provider of community–supported living arrangements;

(9) One representative from the Community Services Reimbursement Rate Commission; ~~and~~

(10) ~~One individual with expertise on rate systems for community services in other states~~ One individual familiar with rate systems for community services in Maryland and in other states; and

(11) One representative from the Developmental Disabilities Council.

(c) The Secretary of Health and Mental Hygiene shall appoint the nondesignated members of the Task Force.

(d) The ~~Task Force members shall elect a chair~~ Secretary of Health and Mental Hygiene shall appoint the chair of the Task Force from its membership.

(e) The Department of Health and Mental Hygiene shall provide staff for the Task Force.

(f) A member of the Task Force may not receive compensation as a member of the Task Force but is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(g) On approval of the Secretary of Health and Mental Hygiene, the Department shall provide assistance to members requiring additional services to attend meetings of the Task Force.

(h) The Task Force shall:

(1) Review the existing rate system for community–based services funded by the Developmental Disabilities Administration and determine its strengths and weaknesses;

(2) Identify current mandates for service delivery;

(3) Consider costs as reported in the Developmental Disabilities Administration's cost report;

~~(3)~~ (4) Compare the cost of current mandates for service delivery to the level of funding provided by the State;

~~(4)~~ (5) ~~Identify~~ Consider promising practices in rate systems in other states that fund appropriate and individualized supports in a cost–effective manner, which are consistent with local and national best practices;

~~(5)~~ (6) Identify changes in the reimbursement system that further support self–directed services and implementation of best practices; and

~~(6)~~ (7) Develop recommendations to address the problem of the structural under–funding of community services.

(i) The Task Force shall report its findings and recommendations by December 31, 2007, to the Governor, and, in accordance with § 2–1246 of the State Government Article, the Senate Finance Committee, the Senate Budget and Taxation Committee, the House Health and Government Operations Committee, and the House Appropriations Committee.

(j) After the Task Force has submitted its final report, the Task Force shall continue to advise the Governor and the Maryland General Assembly on the implementation of its recommendations.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2007. It shall remain effective for a period of 1 year and 1 month and, at the end of July 31, 2008, with no further action required by the General Assembly, this Act shall be abrogated and of no further force and effect.

Approved by the Governor, April 10, 2007.

APPENDIX #2

Maryland Developmental Disabilities Administration

Fee Payment Service (FPS) History

October 12, 2007

- FPS was developed using the Prospective Payment System (PPS) as the base.
- PPS was based on two rates – a client and a provider component.
    - The provider component was based on four cost centers – administrative, general, capital and transportation (A, G, C, & T). Each provider's AGC&T was based on costs reported through cost reports.
    - The client component was for direct care and tied to a matrix of twenty-five levels of need. This component also included regional rate adjustments that increased for certain high-cost areas (Washington and Wilmington Metro) and decreased for rural areas. The client component, with the exception of the regional adjustments, was the same for all providers.
- PPS developed into a system of inequitable payments. Even if the costs for two providers were similar, the provider that was able to document higher costs received higher payments than the provider that was not able to do so.
- DDA implemented cost containment measures on the provider component by placing ceilings floors and ceilings on the year-to-year changes in AGC&T.
- To "fix" PPS, DDA and the provider community developed FPS which is the current payment system used to reimburse providers for residential, day and supported employment services.
- FPS was effective May 1, 1998.
- FPS is also based on two rates – the provider and individual component.
    - The provider component pays a flat rate for A, G, C, & T. This was arrived at in a cost-neutral manner by bringing all providers to the weighted mean AGC&T. Doing so meant some providers gained money and others lost money over the four-year phase-in period.
    - The individual component was unchanged and continued to be based on direct care and tied to a matrix of twenty-five levels of need. This component also included regional rate adjustments that increased for certain high-cost areas (Washington and Wilmington Metro).
- Those agencies with higher provider components than the mean under PPS were phased in under FPS – 3% decrease from the July 1, 1997 funding level as of May 1, 1998; 7% decrease as of December 31, 1998; and 12% decrease as of December 31, 1999.
- DDA continued to fund augmentation contracts for residential and day programs (payments for services not reimbursed through the rates) until July 1, 2002 when these services were reimbursed via FPS add-on rates.
- DDA began reimbursing providers for supported employment services through FPS as of July 1, 2002.
- Problems with FPS
    - FPS is a funding system that reimburses providers for congregate services. This means providers must base their costs on a congregate service model,

and such a model may create problems for providers as they try to deliver individualized services. As an example, if a provider is staffing a three-person ALU and one person moves out, the provider still has the full expenses for the ALU but one-third less revenue.

- FPS's system of add-on components, while solving the problem of separate augmentation contracts, is not fully compatible with the congregate-services funding model. It is difficult to reconcile the additional hours provided with add-ons with the shared hours in the base rates.
- A better system for today's service philosophy would be one similar to the CSLA Payment System in which reimbursement for services is based on each individual's needs.

Department of Health and Mental Hygiene
Cost Report Data Form - FY 2006
Schedule A: Residential Services
Classification of Expenditures

Provider Name:
Provider Number:

	Direct Support Cost Center	Administrative Cost Center	Add on Components	Supplemental Services	Totals
* Salaries and Wages	0	0	0	0	
General Employees	0	29,755,472	38,019	0	29,793,491
Direct Support Employees	127,159,908	0	37,002,517	101,772	164,264,196
Professional Employees	6,519,036	1,547,321	705,858	38,251	8,810,466
* Fringe Benefits	0	0	0	0	
General Employees	0	5,965,191	93,856	0	6,059,048
Direct Support Employees	25,217,517	0	6,914,916	11,894	32,144,327
Professional Employees	1,080,228	255,095	186,132	7,091	1,528,545
Contracted Services	0	0	0	0	
Contracted Staffing-General	0	665,521	0	56,098	721,619
Contracted Staffing-Direct Support	3,848,098	0	224,131	14	4,072,243
Contracted Staffing -Professional	2,033,248	924,850	347,839	59,882	3,365,819
Utilities	6,350,327	1,044,410	2,147	5,188	7,402,072
Food	9,660,089	0	4,333	4,161	9,668,583
Staff Development/Training	692,023	431,129	442	29	1,123,623
Travel-Staff	1,223,438	383,170	16,785	429	1,623,822
Other expenses - attach schedule	9,687,401	5,138,857	399,710	63,939	15,289,908
Rent	10,752,495	1,784,187	5,699	14,944	12,557,325
Medical Supplies/Equipment	982,421	54,504	0	28,503	1,065,427
Equipment/Supplies (non-capital)	3,311,541	1,375,222	22,519	124,703	4,833,985
Insurance (excluding vehicles)	2,444,235	974,100	13,770	4,984	3,437,090
Interest	0	0	0	0	
Capital (excluding vehicle)	4,455,973	280,024	0	2,189	4,738,186
Administrative	0	641,503	0	0	641,503
Depreciation	0	0	0	0	
Building	4,988,625	809,796	7,494	384	5,806,299
Furniture/Equipment	1,136,775	468,826	2,574	5,616	1,613,791
Other capital expenses - attach schedule	1,524,524	223,113	535	121,667	1,869,839
Transportation - Consumers	0	0	0	0	
Salaries	4,135,737	0	0	3,259	4,138,996
Fringe Benefits	682,549	0	0	56	682,605
Vehicle maintenance	1,482,096	0	3,230	75	1,485,401
	0	0	0	0	
	0	0	0	0	
Vehicle depreciation	2,122,899	0	539	7,323	2,130,761
Vehicle insurance	2,044,123	0	0	1,169	2,045,292
	0	0	0	0	
	0	0	0	0	
Interest expense	253,111	0	0	0	253,111
Fuel	1,993,823	0	0	1,654	1,995,477
	0	0	0	0	
	0	0	0	0	
Other expenses - attach schedule	1,187,663	0	93,878	44,025	1,325,565
Grand Total	236,969,901	52,722,291	46,086,922	709,298	336,488,413

APPENDIX #3

Department of Health and Mental Hygiene
Cost Report Data Form - FY 2006
Schedule B: Day Services
Classification of Expenditures

Provider Name:
Provider Number:
Fiscal Year:

	Direct Support Cost Center	Administrative Cost Center	Add On Components	Supplemental Services	Totals
* Salaries and Wages	0	0	0	0	
General Employees	0	11,775,566	11,948	0	11,787,514
Direct Support Employees	30,771,136	0	6,914,142	66,873	37,752,151
Profesional Employees	1,073,529	368,906	132,866	138	1,575,439
* Fringe Benefits	0	0	0	0	
General Employees	0	2,662,381	52,172	0	2,714,553
Direct Support Employees	6,821,078	0	1,490,079	13,382	8,324,539
Professional Employees	249,823	95,048	34,377	28	379,276
Contracted Services	0	0	0	0	
Contracted Staffing -General	0	283,732	0	0	283,732
Contracted Staffing - Direct Support	1,229,668	0	19,690	315	1,249,673
Contracted Staffing -Professional	813,302	154,582	65,842	19,479	1,053,205
Utilities	1,783,689	314,141	3,081	205	2,101,117
Food	1,801,866	0	0	83	1,801,949
Staff Development/Training	153,689	138,335	103	5	292,132
Travel - Staff	345,447	98,726	396	69	444,638
Other expenses - attach schedule	3,059,066	1,899,356	82,784	22,138	5,063,344
Rent	1,928,717	301,221	0	861	2,230,798
Medical Supplies/Equipment	89,567	9,460	0	0	99,027
Equipment/Supplies (non-capital)	1,982,170	412,825	0	1,868	2,396,863
Insurance (excluding vehicles)	509,233	424,531	5,669	69	939,502
Interest	0	0	0	0	
Capital (excluding vehicles)	457,085	123,628	0	30	580,743
Administrative	0	36,618	0	0	36,618
Depreciation	0	0	0	0	
Building	1,361,932	273,923	0	0	1,635,855
Furniture/Equipment	578,129	290,615	0	168	868,912
Other capital expenses - attach schedule	287,426	141,590	2,484	77	431,577
Transportation - Consumers	0	0	0	0	
Salaries	8,247,828	0	59,893	118,819	8,426,540
Fringe Benefits	1,444,904	0	23,253	13,747	1,481,904
Vehicle maintenance	1,764,984	0	8,000	74,185	1,847,169
	0	0	0	0	
	0	0	0	0	
Vehicle depreciation	1,889,471	0	7,500	9,037	1,906,008
Vehicle insurance	1,423,520	0	3,200	10,797	1,437,518
	0	0	0	0	
	0	0	0	0	
Interest expense	388,440	0	0	0	388,440
Fuel	2,481,214	0	8,500	52,415	2,542,130
	0	0	0	0	
	0	0	0	0	
Other - attach schedule	3,595,859	0	32,930	135,274	3,764,064
Grand Total	76,532,773	19,805,163	8,958,908	540,063	105,836,928
%	72.31%	18.71%	8.46%	0.51%	

Department of Health and Mental Hygiene
Cost Report Data Form - FY 2006
Schedule C: Supported Employment
Classification of Expenditures

Provider Name:
Provider Number:

	Direct Support Cost Center	Administrative Cost Center	Add On Components	Supplemental Services	Totals
* Salaries and Wages	0	0	0	0	
General Employees	0	8,104,890	0	344,169	8,449,059
Direct Support Employees	28,557,481	0	1,813,785	91,731	30,462,997
Professional Employees	296,315	88,013	5,027	1,551	390,906
* Fringe Benefits	0	0	0	0	
General Employees	0	1,580,530	26,699	99,172	1,706,401
Direct Support Employees	5,833,055	0	315,748	19,023	6,167,827
Professional Employees	259,307	18,181	826	7	278,321
Contractual	0	0	0	0	
Contracted Staffing - General	0	197,241	0	21,906	219,147
Contracted Staffing - Direct Support	1,221,553	0	4,032	0	1,225,585
Contracted Staffing - Professional	255,799	68,365	5,080	13,895	343,139
Utilities	611,569	244,197	0	22,157	877,922
Food	204,128	0	0	10	204,138
Staff Development/Training	120,417	86,332	0	0	206,749
Travel - Staff	822,919	84,115	2,000	63	909,098
Other expenses - attach schedule	1,307,996	988,512	10,461	2,125	2,309,093
Rent	884,168	195,545	0	28,710	1,108,422
Medical Supplies/Equipment	4,648	9,191	0	0	13,840
Equipment/Supplies (non-capital)	1,265,007	321,067	0	42,241	1,628,315
Insurance (excluding vehicles)	512,260	145,632	0	1,860	659,752
Interest	0	0	0	0	
Capital (excluding vehicles)	284,728	111,023	0	15	395,766
Administrative	0	51,672	0	0	51,672
Depreciation	0	0	1	0	
Building	460,393	279,817	0	58	740,268
Furniture/Equipment	206,550	111,981	0	13,328	331,859
Other capital expenses - attach schedule	62,022	21,811	0	0	83,833
Transportation - Consumers	0	0	0	0	
Salaries	2,993,652	0	10,350	15,681	3,019,684
Fringe Benefits	602,411	0	3,192	2,220	607,823
Vehicle maintenance	888,776	0	2,000	3,054	893,830
	0	0	0	0	
	0	0	0	0	
Vehicle depreciation	777,149	0	2,000	174	779,324
Vehicle insurance	705,077	0	1,000	1,347	707,424
	0	0	0	0	
	0	0	0	0	
Interest expense	44,504	0	200	0	44,704
Fuel	1,710,334	0	4,800	10,660	1,725,794
	0	0	0	0	
	0	0	0	0	
Other - attach schedule	1,835,653	0	0	285,345	2,120,997
Grand Total	#REF!	#REF!	#REF!	#REF!	68,663,689
%	#REF!	#REF!	#REF!	#REF!	

Department of Health and Mental Hygiene
Cost Report Data Form - FY 2006
Schedule D: CSLA Services
Classification of Expenditures

Provider Name:
Provider Number:
Fiscal Year:

	Balance Per Provider Record	Direct Support Cost Center	Administrative Cost Center	Supplemental Sewices	Totals
* Salaries and Wages	0	0	0	0	
General Employees	6,399,098	0	5,555,068	0	5,555,068
Direct Support Employees	25,200,575	22,354,006	0	992,012	23,346,018
Professional Employees	839,557	733,691	18,088	19,400	771,179
* Fringe Benefits	0	0	0	0	
General Employees	1,242,744	0	1,080,512	0	1,080,512
Direct Support Employees	4,823,516	4,215,758	0	131,467	4,347,225
Professional Employees	178,192	154,281	3,571	2,481	160,333
Contracted Services	0	0	0	0	
Contracted Staffing - General	119,920	0	121,655	0	121,655
Contracted Staffing - Direct Support	2,401,719	2,781,459	0	122,234	2,903,693
Contracted Staffing - Professional	655,483	576,892	53,360	13,659	643,910
Utilities	841,873	452,372	131,674	73,340	657,386
Food	953,793	592,987	0	131,356	724,343
Staff Development/Training	226,477	92,833	75,591	0	168,425
Travel-Staff	737,130	618,605	75,529	33,611	727,745
Other expenses - attach schedule	4,220,158	2,841,600	741,521	512,209	4,095,329
Rent	2,524,970	1,633,234	386,162	469,805	2,489,201
Medical Supplies/Equipment	98,237	80,096	2,677	10,953	93,726
Equipment/Supplies (non-capital)	817,178	476,079	237,697	25,169	738,945
Insurance (excluding vehicles)	493,703	210,289	153,456	2,067	365,811
Interest	0	0	0	0	
Capital (excluding vehicles)	475,854	92,339	46,333	1,177	139,849
Administrative	49,511	0	44,815	0	44,815
Depreciation	0	0	0	0	
Building	637,411	137,819	102,765	877	241,461
Furniture/Equipment	187,208	45,988	60,670	298	106,957
Other capital expenses - attach schedule	133,497	52,108	42,373	21,603	116,084
Transportation - Consumers	0	0	0	0	
Salaries	704,582	581,082	0	10,334	591,416
Fringe Benefits	125,736	108,528	0	1,910	110,438
Vehicle maintenance	160,923	45,283	0	0	45,283
Company-owned vehicles	91,291	99,025	0	19,637	118,662
Consumer-owned vehicles	300	300	0	0	300
Vehicle depreciation	310,865	169,422	0	1,765	171,187
Vehicle insurance	173,286	54,757	0	880	55,637
Company-owned vehicles	97,345	119,012	0	3,253	122,265
Consumer-owned vehicles	240	240	0	0	240
1	0	0	0	0	
Fuel	190,289	46,161	0	0	46,161
Company-owned vehicles	172,297	208,553	0	16,515	225,068
Consumer-owned vehicles	701	701	0	0	701
Other - attach schedule	128,006	69,503	0	7,822	77,325
Grand Total	#REF!	#REF!	#REF!	#REF!	51,204,353
$		#REF!	#REF!	#REF!	

Department of Health and Mental Hygiene
Cost Report Data Form - FY 2006

Provider Name:
Provider Number:
Fiscal Year:

Reconciliations

Expenditures	**Direct Support Cost Center**	**Administrative Cost Center**	**Add On Components**	**Supplemental Services**	**Totals**
Schedule A Totals: Residential	235,873,813	52,702,469	45,914,002	611,847	335,102,131
Schedule B Totals: Day	76,515,238	19,804,580	8,958,906	558,203	105,836,926
Schedule C Totals:Supported Employment	52,792,335	12,705,909	2,203,199	1,024,503	68,725,946
Schedule D Totals: CSLA	39,301,237	8,891,977		2,631,234	50,824,448
Other expenses (all other programs)					272,903,171
Totals	404,482,623	94,104,934	57,076,107	4,825,787	
Grand Total					833,392,622

*** This total should reconcile with the audited financial statements.**

1	1	1	1	1	1

Revenue (See instructions regarding the necessary certification by a CPA.)

	Residential	**Day**	**Supported Employment**	**CSLA**	**Totals**
Contribution to Care (consumer fees)	24,556,102				24,556,102
Local funding		3,435,729			3,435,729
FPS/CSLA payments	293,777,367	85,696,291	47,022,788	52,302,769	478,799,215
Other revenue	16,203,253	16,355,433	14,251,477	1,188,637	47,998,800
Other revenue (all other programs)					312,148,948
Totals	334,536,722	105,487,453	61,274,264	53,491,407	
Grand Total					866,938,794

*** This total should reconcile with the audited financial statements.**

APPENDIX #4

Maryland Developmental Disabilities Administration

DD Services Payment Systems of Other States

October 12, 2007

Alabama

Alabama uses standard rates for day habilitation services. They have eight levels of payments: four levels without transportation and four levels with transportation (reimbursed at $6 per day). The first three levels of each are determined using the ICAP (Inventory for Client and Agency Planning) assessment tool and the fourth level for each is for people needing 1:1 support. The transportation rates are used if the provider must transport the individual at least ten miles as the crow flies.

The residential rates are determined by a spreadsheet completed by providers. The provider fills in how many hours of support a person needs during the day and at night and also enters the number of people to be served at the site. The spreadsheet then calculates the rate of reimbursement. Alabama is spending $179 per day on average for residential services, or about $65,000 per year.

Arkansas

Arkansas uses a cost-reimbursement system based on review of individual plans. Plans are reviewed and services and costs are preapproved up to a maximum for the service. The maximum for individual or group supportive living is $160 per day, or about $58,000 per year. The maximum for their "pervasive level of support" is $356.32 per day or about $130,000 per year. If the plans indicate the high cost level, then a standardized assessment (they use the ICAP) must be administered and other documentation provided before the high costs are approved. If consumers share staff, as in a congregate setting, then the staff costs is divided equally or prorated according to the individuals' needs.

Georgia

Georgia pays an hourly, daily, or monthly rate based on the type and frequency of service. The service components and frequency are determined by the Individual Service Plan. They have recently started using the AAIDD Supports Intensity Scale (SIS) to help determine the services, and their intensity, to be included in the ISP.

For residential services, Georgia pays a daily rate of $155.56 per day for 324 days (6.2 days per week), which equates to $50,401 per year. Day services may include day habilitation, supported employment, or day supports. Day Habilitation is the traditional facility-based service and is reimbursed hourly up to $17,510 per year. Supported employment is reimbursed hourly up to $6,912 per year. Day supports may include facility-based services but must include nonfacility community activities. Day services are paid by a monthly unit unless an individual is not able to receive a minimum number of hours per month, in which case hourly units may be billed. The

monthly rate is $870.83, or $10,450 per year. Georgia is planning to implement new payment systems as a result of the recent approval of new HCBS Waivers.

Kentucky

Kentucky pays per diem rates for residential-type services. Foster care is reimbursed at $112.49 per day ($41,059 per year), group homes are paid $126.35 per day ($46,118 per year), and staffed residences (small individualized homes) receive $168.46 per day ($61,488 per year).

Day services, called "Adult Day Training," are reimbursed in fifteen-minute increments equating to $10–$12 per hour, depending whether the service is on or off site. Kentucky also adds intensity payments to the standard rates for individuals with high NC-SNAP (North Carolina-Support Needs Assessment Profile) scores.

Mississippi

Mississippi pays $55 per day ($20,075 per year) for supervised residential habilitation apartments serving no more than three individuals who receive 24/7 support. However, the providers of these services are regional centers, schools, and mental health centers, so it is possible the rate does not cover costs that may be subsidized by other means. Mississippi also pays $21 per hour for supported living using on-call staff for a maximum of seven hours per week. Day habilitation is paid at $14.28 per hour and prevocational services receive $11 per hour. Again, these providers are regional centers, schools, and mental health centers.

North Dakota

North Dakota offers a range of residential and day services, including supported living arrangements, apartments, supported employment, and day programs. With all of the services, the North Dakota Department of Human Services negotiates initial rates with each provider at the beginning of the fiscal year, requires the providers to submit audited cost reports after the fiscal year is over, and reconciles payments to each provider's costs.

Ohio

Ohio has guidelines for paying for homemaker/personal care staff employed by companies and for those independently employed. Direct-support staff is paid $10.39 plus fringe, and supervisors are paid $15.86 per hour plus fringe.

APPENDIX #5

STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

Developmental Disabilities Administration
Michael S. Chapman, Director

TO: DDA Rate Task Force Members

FROM: Audrey S. Waters
Acting Deputy Director

DATE: November 21, 2007

RE: Information

****

Attached are several documents to review before our next meeting:

- CSRRC Analyses of FY 2006 Cost Reports
- CSRRC Direct-Support Worker Wage Rates of DDA Providers – Fiscal Year 2006
- CSRRC The Financial Situation of Providers of Community Services Contracting with DDA, Fiscal Years 1999 through 2006
- State of the States in DD:2005 – Waiting List Information
- Individual Indicator Rating Scale Information
- Developmental Disabilities Support Needs Assessment Profile (DD-SNAP) Information
- AAMR-Supports Intensity Scale (SIS) Information
- Inventory For Client and Agency Planning (ICAP) Information

Have a happy holiday, I look forward to seeing you at our next meeting

South Dakota

South Dakota uses spreadsheet models to determine individual costs using such factors as ICAP scores, type of service, number of hours of service, medical services needed, and county economic adjustments. Answering questions and filling in data on the spreadsheets produces per-diem rates for each person.

Texas

Texas uses standard rates for their community services. They pay per-diem rates for residential and day habilitation services. For residential services, the rates range from $87.97 to $129.56 per day ($32,105–$47,289) based on level of need. They pay $211.72 per day ($77,278 per year) for a high level of need individual. For day habilitation, the rates are $18.47 to $46.18 per day ($4,618–$11,545 for a 250-day year) with a high need rate of $184.75 per day, or $46,188 per year. Supported employment is paid with and hourly rate of $23.52, and supported living is paid with an hourly rate of $17.75.

Washington

Washington recently developed a new assessment process and rate calculator that is scheduled to be fully implemented by July 1, 2008. The system uses the SIS to determine six levels of support, and the rates have an economy of scale adjustment. Washington currently is paying on average $194.21 per day ($70,887/year) for supported living and $268.69 per day ($98,072/year) for staffed residential services.

Community Services Reimbursement Rate Commission

Analyses of FY 2006 DDA Cost Reports

June 2007

Executive Summary

Providers appear to be incurring losses on day and supported employment programs. These losses may be due to increased transportation costs. Residential services generally operated at a slim positive margin in 2003 and 2006, and a slim negative margin in 2004 and 2005. CSLA services were generally profitable in 2006, as was the case in prior years.

Introduction

The CSRRC is required by its enabling legislation to:

> Review the data reported in the Developmental Disabilities Administration Annual Cost Reports and use the data to develop relative performance measures of providers.

To this end 120 Cost Reports for fiscal year 2006 were obtained from the Developmental Disabilities Administration (DDA), key fields from these cost reports were extracted and input into a database for analysis, and the analysis described in this report was then carried out.

To avoid any misunderstanding it will be worthwhile to discuss how the term "relative performance measures" is being interpreted for this purpose. The cost reports provide data on costs, revenues and utilization, so the performance measures that can be generated using the Cost Reports are necessarily financial and utilization measures. Accordingly, the measures that result are comparisons of providers with one another. As such they do not represent comparison with some objective standard. It will not be possible to develop outcomes measures from these data.

Questions to be addressed

Some specific questions will be addressed by this analysis. The first item will be to provide some general descriptive information regarding the range of services provided. The second will be the relative profitability of the different types of services provided, i.e., day services, residential services, employment services, and community supported living arrangements (CSLA), in total and by provider. The FPS includes two components to rates: a client component that varies depending upon client needs, and an administrative component that is a fixed amount per day for the particular service. In response to the directive to study transportation costs the transportation costs and mileages will be studied.

Analysis and results

Descriptive statistics

The following table presents some summary statistics from the Cost Reports. In this table medians are presented rather than means as they are less influenced by outliers.

Table 1: Summary statistics, fiscal year 2006

	CSLA	Residential	Day	Employment
# of providers	71	96	62	65
Median Margin	9.33%[1]	0.54%[1]	-0.20%[1]	-5.20%[1]
Median Cost/Day	$83.70	$192.78	$70.85	$70.86
Percentage of revenue	10%	60%	19%	11%

These data suggest that providers are profiting from the provision of CSLA services, and are generally losing money on supported employment services. These results are generally consistent with the results found for fiscal years 2002 through 2005. CSLA services were implemented relatively recently, and recently enrolled clients are reported to be more profitable than clients who have been with a provider for an extended period of time. The payments for CSLA comprise only about 10% of the total expenditures on community services.

Transportation costs

The FY 2003 Cost Report was the first in which detailed data on transportation costs and utilization were collected. These data were examined and large differences among providers in transportation costs were noted. However, due to problems with the data reported the analysis of transportation costs was delayed. The quality of the transportation data did appear to be somewhat improved in the FY 2004 Cost Reports, although there were still some obvious problems. The survey forms and instructions were substantially revised for the FY 2005 survey to reduce any ambiguity as to what should be reported. The FY 2006 Cost Report used the same forms as the FY 2005 Cost Report. While the data have improved over time, there are clearly inconsistencies in the ways in which the transportation cost data are being reported, so the results presented below should be interpreted with caution. This is particularly the case for results by

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[1] The median margin was calculated by first calculating the margin for each provider, then calculating the median of these margins. It is not calculated from the median revenue and median expense.

region, where the number of providers included is often quite small.

The following tables provide summaries of the transportation costs per day and per mile.

Table 2: Transportation cost per client per day

	Day	Supported Employment	CSLA	Residential[2]
State Median	$11.99	$8.94	$2.92	$6.77
Central median	$11.35	$10.54	$3.06	$7.31
East median	$9.97	$7.73	$2.11	$4.90
South median	$16.65	$9.10	$2.83	$10.55
West Median	$11.58	$8.64	$2.45	$5.51

The numbers of cases within the regions are small, so the medians are subject to statistical variations.

Table 3: Transportation cost per mile

	Day	Supported Employment	CSLA	Residential
State Median	$1.58	$1.02	$0.72	$0.61
Central median	$1.42	$1.24	$1.57	$1.40
East median	$1.10	$0.67	$0.63	$0.31
South median	$2.64	$1.06	$0.44	$0.72
West Median	$1.77	$0.74	$0.72	$0.11

The numbers of cases within the regions are small, so the medians are subject to statistical variations.

Table 4: Median numbers of clients and miles per trip

	Day	Supported Employment	CSLA	Residential
Number of clients	8	4	1	3
Miles per trip	42	30	23	24

Caveats and comments

Transportation costs are a major issue for day and supported employment services. For residential services providers the transportation requirements are smaller, and more varied in their nature, with transportation of residential clients to day programs generally being provided by the day program.

[2] The Commission considers the residential transportation costs reported here to be rather high given the nature of the transportation services provided to residential clients, and the fact that the transportation to day programs is generally provided by the day program rather than the residential program. This issue will be revisited when the FY 2007 Cost Reports become available.

The data still show substantial variation between providers in the costs. By reporting medians the impact of these variations is reduced, but not eliminated.

The capital cost for vehicles is based on depreciation. This underestimates the real cost in that it does not account for inflation. Also, many providers are likely to have vehicles that are fully depreciated so are not contributing any depreciation cost.

Conclusions

Providers appear to be incurring losses on day and employment programs. These losses may be due to increased transportation costs. Residential services operated at a slim positive margin in 2003 and 2006, and a slim negative margin in 2004 and 2005. CSLA services were generally profitable. Even in services in which the median margin is positive there are still a substantial number of providers with negative margins, and conversely for services in which the median margin is negative.

Direct-Support Worker Wage Rates of DDA Providers - Fiscal Year 2006

Executive Summary

The results reported in this paper are based on wage surveys of providers contracting with DDA. The data on wages were for a pay period in February 2006 and for the entire fiscal year 2005, as well as pay period surveys from prior years. The data reported has been checked by DDA and CSRRC staff. In addition, the providers have been required, since 2004, to have the data attested to by their independent auditors.

The wage rates of Direct-Support Workers increased by 6.3% from FY 2004 to FY 2005 and by 1.8% from FY 2005 to FY 2006. The wage rates of first line supervisors increased by 7.8% from FY 2004 to FY 2005, then declined by 1.3% from FY 2005 to FY 2006.

The fringe benefit percentage and the amount paid as bonuses were basically unchanged between 2004 and 2005.

Through FY 2005 fringe benefits remained relatively constant at 20% of wages, although the amount paid for fringe benefits increased by $6.4 million from FY 2004 to FY 2005.

Data on bonuses and fringe benefits are naturally reported on an annual basis, not for a pay period, so are gathered in December. As a result the data for FY 2006 on bonuses and fringe benefits are not yet available, and the data provided for these elements are for FY 2005.

The direct-support worker hourly wage rate for FY 2005 reported in the Annual Wage Survey was very close to that reported in the February 2005 pay period survey.

Introduction

The Community Services Reimbursement Rate Commission (CSRRC) is required by its enabling statute to compare the increase in the wages paid by providers of community services that contract with the Developmental Disabilities Administration (DDA) with the rate increases provided in the rates paid by DDA. In order to comply with this requirement the CSRRC designed a survey instrument, and each year, in cooperation with DDA, carries out a survey of these providers. The most recent survey asked for information on wages paid during a pay period in February 2006. Surveys were sent to 120 providers and 118 of these providers responded to the survey. Two of the responses were not usable for purposes of this analysis, so 116 responses were used for the analysis reported below.

DDA is collecting Annual Wage Surveys that are due December 1 following the end of the fiscal year. These Annual Wage Surveys will replace the February pay period survey in future years, so no pay period survey is planned for 2007.

This paper reports the results and conclusions from the February 2006 pay period survey, compares the results of the FY 2005 Annual Wage Survey and the February 2005 pay period survey, and provides trends in the wage rates, fringe benefit percentages, staff turnover rates, and vacancy rates.

Design and testing of the survey instrument

The first step in the design of the survey instrument was a review of survey instruments previously used to collect data from these providers. The design of the survey instrument was done in conjunction with the Technical Advisory Group on DDA issues, who reviewed the instrument, provided input on the types of data available and nomenclature, and suggested changes. The instrument used in FY 2000 had been field tested by two providers, and modified based on their input prior to its use. Based on the response to that survey, and the FY 2001 survey, additional minor changes were made to the FY 2002 survey form. The survey forms used for FY 2003 were expanded to include more detail on fringe benefits and bonuses. The survey, without the fringe benefit form, and with some minor editorial changes was used again in FY 2004. For FY 2005 the survey form was simplified by combining Aides and Service Workers into a Direct-Support Worker category and the same form was used for FY 2006 Prior to the due date for the FY 2005 survey three educational sessions were provided to instruct providers on the purposes of the survey and how the forms should be completed.

The Annual Wage Survey form was based on the survey instrument used for the pay period survey, but was somewhat simplified, as the reporting of base and overtime wages and hours were combined.

The data were checked extensively once received. Overall reasonableness checks were made by both DDA and CSRRC staff, and the data were compared with the corresponding data submitted

Comparison of the FY 2005 Annual Wage Survey and the pay period survey

The February pay period survey is being replaced by an annual Wage Survey which will be due from providers on December 1, and will include data for the entire fiscal year. However, in order to maintain the ability to analyze trends in the wage rates of the direct-support workers both surveys were conducted for fiscal year 2005, and both will again be conducted in fiscal year 2006. The Annual Wage Survey instrument was based on the instrument that was used for the February pay period survey, but was simplified by combining the base and overtime hours and wages, since it was thought that it would be difficult for providers to separate base and overtime data when reporting the entire year. The following table compares the results for full time direct support workers in the two surveys:

	Pay Period Survey - 2005	FY 2005 Annual Wage Survey
Direct-support wage rate	$10.37	$10.36
Mean Tenure	43 months	43 months
Turnover rate	35%	32%

These results are remarkably similar, particularly given that the Annual Wage Survey wage rate includes overtime hours and wages, while the pay period results are just for base wages. While the pay period survey wage rate including overtime was $10.65, the Annual Wage Survey wage rate would be expected to be lower than the February pay period wage rate because some employees receive their increases after July 1, but most have received them by February, offsetting the effect of the inclusion of overtime in Annual Wage Survey data in the table.

Staff turnover rates and tenure

The turnover rates for the employees categories for all services were:

	2004	2005	2006
Direct-support workers	38%	34%	40%
First line supervisors	19%	18%	25%

These turnover rates are substantially lower than those experienced by the providers when this survey was started in the 1990s. At that time the turnover rate in Maryland was around 50%. The literature documents turnover rates nationally from a low of 40% to over 75%. The

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direct-support workers working in the community received 17.7% wage increases over the period 2001 to 2006. In most years state workers who are not at the top of their scale receive an annual wage increment. However, regular wage increments were not provided in 2004.

in the prior year. Where errors were found the provider was asked to resubmit corrected data. Starting for FY 2004 the providers were required by DDA to have their auditor certify the data provided in the survey form. These certifications are due to DDA December 1 following the date of the survey. This requirement has resulted in some corrections being filed when the auditors check the data.

Data on bonuses and fringe benefits are naturally reported on an annual basis, not for a pay period, so are gathered in December. As a result the data for FY 2006 on bonuses and fringe benefits are not yet available, and the data provided for these elements are for FY 2005.

Results of the pay period survey

The pay period survey found the following state-wide full time base wage rates (excluding fringe benefits):

Wage category	Direct-Support Worker	1st line supervisor
FY 2001	$8.96	$14.82
FY 2002	$9.31	$15.17
FY 2003	$9.69	$15.73
FY 2004	$9.75	$16.50
FY 2005	$10.36	$17.78
FY 2006	$10.55	$17.55
% change from 2001-2006	17.7%	18.4%
% change from 2005-2006	1.8%	-1.3%

Corrections were received to prior year surveys, so the figures listed in the table above may differ from those reported in previous reports on the wage survey.

The wages of drivers decreased from $10.26 in 2005 to $10.15 in 2006, a decrease of 0.1%.

State direct support workers received wage increases increase from 2001 to 2006 of about 8.7%. In comparison the direct-support workers in community providers received 17.7% wage increases over the period 2001 to 2006.[1]

[1] State direct support workers received a 4% increase for FY 2002, no increase in FY 2003 and 2004, and an increase of $752 in FY 2005 (i.e., about 3%) and the increase in FY 2006 was 1.5%, for a combined percentage increase from 2001 to 2006 of about 8.7%. In comparison, the

Fringe benefits

The fringe benefit survey for fiscal year 2006 will be collected in conjunction with the submission of the Annual Cost Reports in December, since the providers will then have complete data on their fringe benefit expenses for FY 2006. The data presented in this section is from prior surveys.

The fringe benefit percentage reported is an overall percentage for all employees for the year, in contrast to the wage rate data reported here, which is for specific employee categories. The following table summarizes the results from prior year surveys.

Fringe benefit percentage by fiscal year

Fiscal Year	# providers	Mean FB %	Median FB %
2001	96	20.7%	20.0%
2002	97	19.7%	19.6%
2003	111	20.4%	20.0%
2004	114	20.4%	19.3%
2005	115	20.4%	19.8%

There was no substantial change in fringe benefit percentages in the period 2001 to 2005. However, even with the percentage remaining constant, the dollar amount of fringe benefits increases as the amount of wages increases, but it should be noted that this effect is budgeted for in the $80 million wage initiative.

DDA has calculated the current state fringe benefit percentage to be 30.4%. This is substantially higher than that of the providers.

The two items comprising the largest proportions of fringe benefits (almost 40% of the total fringe benefits each) were the employer proportion of FICA and health insurance. Retirement costs and retirement plan administration made up 10% of the total fringe benefit costs. Employees are contributing an additional 25% of the total employer fringe benefit costs as the employee portion of these costs.

Bonuses

In both 2004 and 2005 the amount reported as being paid in bonuses to Direct-support workers was $2.2 million.

reduction in turnover may be due, in part, to the increase in the wage rates. The level of unemployment also influences turnover rates. The following table shows the unemployment rate in Maryland and uses data from the Bureau of Labor Statistics:

Maryland Unemployment Rate (data from BLS)

Year	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Rate	4.9	4.8	4.3	3.6	3.6	4.1	4.5	4.5	4.3	4.1

The turnover rates of state employee categories are much lower than those experienced by the providers.

The average tenures of staff and the percentages of the direct-support employees in each category were:

Job category	Average tenure 2004	Average tenure 2005	Average tenure 2006	% of employees in the category in 2006
Direct-support worker	42 months	44 months	44 months	88%
1st line supervisor	61 months	68 months	72 months	12%

The average tenures of state employees in corresponding positions are much longer than the tenures of the service workers in the community service providers.

Tenure can be influenced substantially by long term employees.

Change in wage rates

The Commission has a responsibility to compare the change in wage rates with the change in payment rates for services. The rates were increased effective July 1, 2005 under the wage equalization initiative sufficient to increase direct support worker wage expenditures by 3.2%, and with an equal amount to increase fringe benefits. The increase in direct-support worker wages, at 1.8%, is less than the 3.2%. The fringe benefit increase in fiscal year 2006 will not be available until after December 2006. However, the percentage that fringe benefits comprise of total wages has been relatively constant through 2005, and based on prior experience would not be expected to change much. While the dollar expenditures on fringe benefits have increased as the wage rates have increased, the wage equalization program had intended that the fringe benefits would increase as a percentage of total wages, and this does not appear to have occurred and was probably not a realistic expectation. Fringe benefits have remained relatively constant at about 20% of wages and salaries. DDA reported that the dollar amount of fringe benefits paid to workers in residential, CSLA, day and supported employment services, as reported in the FY 2004 and FY 2005 Cost Reports, increased by $6.4 million.

Rate increases

DDA has provided the Commission with information on the rate increases provided, as a percentage of total wages and as a percentage of direct service workers wages. From 2005 to 2006 the increases in direct-support wages were less than the rate increase. The wage equalization initiative provides funds to allow providers to increase the wage rates of direct-support workers, with the intent of bringing these wages to the level of corresponding state direct-support workers. Direct-support worker wages comprise about 45% of the total costs of providers, so increased funding sufficient to increase direct-support workers wages by 5% results in an overall rate increase of about 2.5%. In making the comparison between rate increases and wage increases the Commission usually compares the wage increases with the overall rate increase. This is done because the providers are experiencing increases in their other costs, as well as the wages paid to direct-support workers.

Data quality caveats

In prior years there appeared to be inconsistencies in the way in which employees were classified within providers from year to year. Two actions were taken to reduce or eliminate these, and other, problems: 1) starting in FY 2004 the providers were required to have their surveys attested to by an independent CPA; and, 2) the wage surveys through 2004 split the workers into three categories, aides, service workers, and first line supervisors. For the FY 2005 survey the aide and service workers categories were combined into a single category designated Direct-support Workers.

The reviews by DDA and CSRRC staff identified data elements that were clearly in error, and the providers were asked to resubmit these data. Hourly wage rates that were unreasonably high

or low, tenures that appeared unreasonable or impossible, and other such aberrations, were identified. The corrected surveys replaced the original data in the analysis.

Summary

The wage rates of Direct-support Workers increased by 1.8% from FY 2005 to FY 2006. The wage rates of first line supervisors decreased by 1.3%.

Bonuses remained constant is dollar terms between 2004 and 2005.

There was no substantial change in fringe benefit percentages in the period 2000 to 2005. However, even with the percentage remaining constant, the dollar amount of fringe benefits increases as the amount of wages increases, but it should be noted that this effect is budgeted for in the $80 million wage initiative.

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The Financial Situation of Providers of Community Services Contracting with DDA, Fiscal Years 1999 through 2006

12 June 2007

Executive Summary

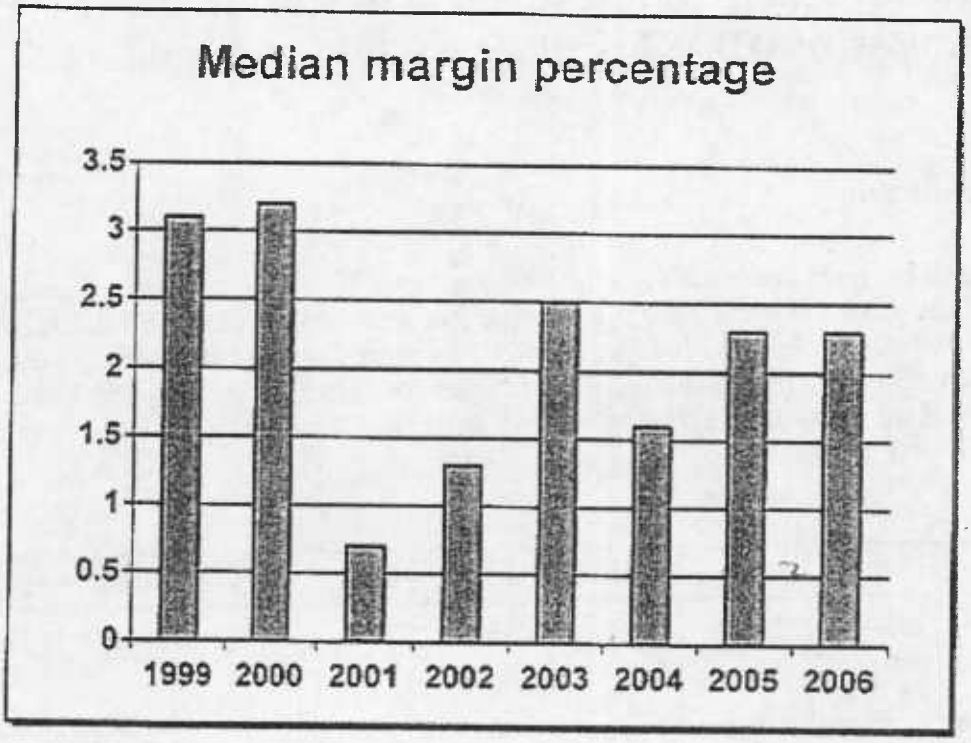
The ratios examined are in a reasonable range for fiscal years 1999 through 2006. These ratios indicate that fiscal years 1999 and 2000 were similar, but with a deterioration in FY 2001. The margins recovered slightly in 2002 and further in 2003, declined in 2004, but margins recovered in 2005 and 2006 to almost the 2003 level. The indicators in Table 1, combined with the drop in the weighted mean margin, show a slightly weakening trend in the financial condition of the providers from 2005 to 2006.

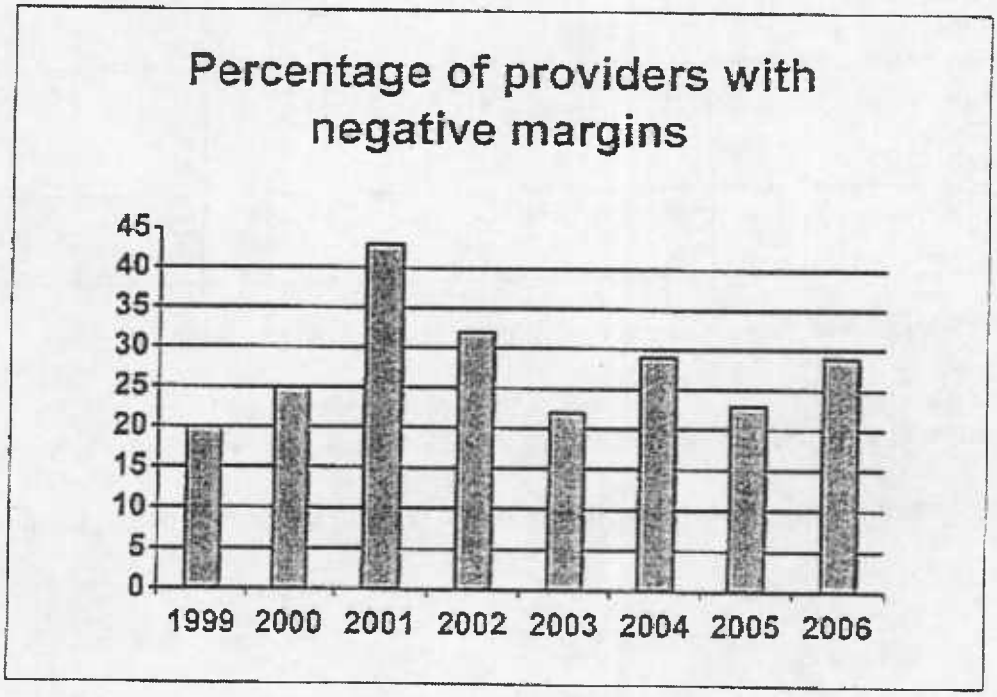
Table 1	1999	2000	2001	2002	2003	2004	2005	2006
% with negative margins	20%	25%	43%	32%	22%	29%	23%	29%
Median margin	3.1%	3.2%	0.7%	1.3%	2.5%	1.6%	2.3%	2.3%
Median current ratio	1.9	1.4	1.8	1.7	1.8	1.7	1.7	1.4
Number with negative net assets	3	2	7	3	3	6	5	5
% with current ratio < 1	23%	26%	31%	28%	20%	24%	27%	27%

A more detailed discussion of the results can be found in Section 4 of this paper.

Margins declined slightly from 2005 to 2006, and the percentage of providers with negative margins increased, suggesting a deterioration in the overall financial situation of the providers.

The Commission continues to find that bad debts are not an issue of concern for these providers.


Median margin percentage
3.5
3
2.5
2
1.5
1
0.5
0
1999 2000 2001 2002 2003 2004 2005 2006


Percentage of providers with negative margins
45
40
35
30
25
20
15
10
5
0
1999 2000 2001 2002 2003 2004 2005 2006

1. Introduction

The enabling statute of the Community Services Reimbursement Rate Commission (CSRRC) requires that the Commission, in its evaluation of rates, consider "the existing and desired ability of providers to operate on a solvent basis in the delivery of effective and efficient services that are in the public interest". The analysis reported here is intended to examine the financial status of the providers of community services to individuals with developmental disabilities and show trends for the fiscal years 1999 through 2006.

A number of caveats need to be made to avoid reading too much into this data. The first is that there is no single financial measure that gives a complete picture of the financial situation of a provider. Therefore, it is necessary to examine several indicators to obtain an overall picture. The second caveat is that the payment systems have undergone substantial changes over the past several years, and these changes are likely to have caused some of the differences observed between the years reported here. A third is that the expenses and payments are not just those associated with services paid for by the state, so this is not simply an analysis of the impact of the DDA payment system. Another caveat is that the set of providers reporting is not the same in each year, although the increased response rate makes this less of an issue in recent years. A separate analysis using Cost Report data and focusing on DDA revenues and expenses is planned.

The paper starts with a summary of the most important results, then continues with a description of the data sources, and a more detailed presentation of the results of the analysis.

2. Data sources

The data used for this analysis were extracted from the fiscal year 1999 through 2006 Audited Financial Reports.

Table 2: Number of reports included in the analysis

Year	1999	2000	2001	2002	2003	2004	2005	2006
No. of reports	84	89	94	103	104	106	102	100

Providers are required by regulation to provide their Audited Financial Reports. Usable financial reports from 100 providers were available for FY 2006 out of a total possible of about 120. Of the 100 providers used for the 2006 analysis, 39 were from the Central Region, 15 from the Eastern Region, 29 from the Southern Region, and 17 from the Western Region.

The following data fields were extracted from the fiscal year 2006 Financial Reports (definitions of the terms are included in Attachment 1):

Total expenses
Total revenues
Current assets
Total assets
Current liabilities
Long term liabilities
Total liabilities
Contributions
Cash and investments
Receivables
Bad debts

3. Financial ratios calculated

The Commission's statute focuses on solvency. A literal interpretation of solvency is that sufficient cash is available to pay all just debts. Data on cash flows is not generally available from providers on a consistent basis, if at all. The accounting profession has traditionally used various financial ratios to measure the condition and performance of organizations and the Commission believes that the legislature intended an examination of financial condition rather than literal solvency. Accordingly, the Commission has used the data available from Audited Financial Reports to construct financial ratios for use in evaluating the financial condition of the providers.

The data were used to calculate five financial ratios or indicators that are generally considered to be indicative of the financial health of a provider. These were:

Profit margin:	(Total revenues - Total expenses)/Total revenues
Current ratio:	Current assets/Current liabilities
Net assets:	Total assets - Total liabilities
Days in receivables:	(Receivables/revenues) x 365
Days of cash:	(Cash/expenses) x 365

Several providers had large profits or losses, but only a small proportion of their business is with Maryland DDA. In order to adjust for this starting in FY 2000 the mean ratios were calculated weighting the results by the total Maryland DDA payments to the provider. These payments included CSLA, FPS, and contracts. Consideration was given to dropping from the analysis providers whose revenue was largely from sources other than Maryland DDA, but it was found that weighting by DDA payments provided similar results for the ratios, and shows a more complete picture of the financial condition of all the providers.

Most providers are on the accrual basis of accounting for their financial records, which recognizes revenues and expenses as they occur throughout the reporting period. This is different from the relative levels of cash providers have, which is influenced by the increases or decreases

in accounts receivable and accounts payable. Implicitly, the provider's cash position is affected by its payor mix and how quickly its largest payor is billed by the provider and in turn how quickly the payor pays those bills. Accordingly, both profit margin and cash position are important determinants of a provider's financial position.

4. Results

4.1 Profit Margin

The term "profit margin" is used as it is generally understood. However, it should be noted that while most of the providers are "not-for-profit" organizations, all organizations require some level of profit in order to sustain their existence and build up funds to replace their buildings and equipment. In addition, the revenues reported by some providers included grants that were used to pay for capital acquisitions rather than for operating expenses.

The margin (profit margin) is probably the most important indicator of the financial health of an industry (and an individual company), as it shows whether the industry is covering its costs and has the capacity to accumulate reserves for future investment. The mean margin of the providers of community services reporting to DDA was 3.2% in FY 1999, 3.5% in FY 2000, 0.4% in FY 2001, 1.8% in FY 2002, 2.5% in FY 2003, 1.6% in FY 2004, 1.9% in FY 2005, and 1.5% in FY 2006. The spread of the margins is shown in Table 3. The margins (as well as the other ratios examined) in 1999, 2000 and 2001 could have been affected by the phase-in of the FPS, which was completed in FY 2001.

Table 3: Profit Margins	1999	2000[1]	2001[1,2]	2002[1]	2003[1]	2004[1]	2005[1]	2006[1]
75th percentile[3]	8.3%	8.1%	3.9%	5.6%	6.7%	4.6%	5.2%	4.7%
50th percentile (Median)	3.1%	3.2%	0.7%	1.3%	2.5%	1.6%	2.3%	2.3%
25th percentile	0.0%	0.0%	-2.8%	-1.5%	0.1%	-0.3%	0.0%	-0.5%
Mean	3.2%	3.5%	0.4%	1.8%	2.5%	1.6%	1.9%	1.5%

[1] Mean margin weighted by DDA payments.

[2] FY 2001 represents a low point in the profit margins, and this coincides with the last year of the phase-in of the FPS. In FY2001 several providers experienced negative adjustments to their rates as a result of this phase-in, but none received positive adjustments.

[3] The 75th percentile is that level at which 75% of the providers have values below this level, and 25% has values above this level. This, together with the 25th percentile, provide a measure of the spread in the values being reported.

Of the providers of community services included in this study for FY 2006 29 of the 98 had negative margins in FY 2006 (i.e., 30%). For each of the years the margins were not statistically significantly correlated with the size of the provider, although the small providers generally had the greatest range in their margins.

4.2 Profit margins by region of the state

Table 3A shows the mean profit margins (DDA revenue weighted for 2000 through 2006) for the providers located in the 4 DDA regions of the state for FYs 1999 through 2006* and Table 3B shows the median profit margins[4] for 1999 through 2006.

* In FY 2006 contributions made up 2.7% of the total revenue of the providers in the study. The contributions are distributed unevenly over the providers, with a few providers receiving a large amount in contributions, and other providers receiving little or nothing. Many providers receive contributions mainly for capital or special projects, rather than for operations.

Table 3A: Mean profit margin by region	1999	2000[5]	2001[5]	2002[5]	2003[5]	2004[5]	2005[5]	2006[5]
Central (Baltimore & area)	3.0%	2.0%	0.3%	1.6%	1.3%	0.2%	1.1%	-0.2%
East (Eastern Shore)	8.2%	5.5%	-0.5%	2.5%	6.2%	4.5%	2.6%	3.0%
South (Washington suburbs & Southern tri-county area)	2.3%	5.2%	1.2%	2.9%	4.0%	2.9%	2.7%	2.7%
West (Western Maryland)	3.2%	3.5%	-1.3%	-0.2%	1.1%	1.0%	2.3%	2.6%
State	3.2%	3.5%	0.4%	1.8%	2.5%	1.6%	1.9%	1.5%

[4] The mean can be moved substantially by one or two outlier values, but the median (the middle value when the values are arranged in order) is less affected by outliers, and so is also reported here.

[5] Weighted by DDA payments.

Table 3B: Median profit margin by region	1999	2000	2001	2002	2003	2004	2005	2006
Central (Baltimore & area)	2.9%	1.4%	0.2%	1.3%	2.5%	1.1%	2.2%	2.0%
East (Eastern Shore)	6.7%	3.6%	0.0%	1.6%	6.7%	3.5%	2.8%	4.4%
South (Washington suburbs & Southern tri-county area)	2.5%	6.2%	2.7%	1.2%	1.1%	3.1%	1.7%	1.8%
West (Western Maryland)	2.6%	2.2%	-0.3%	-0.8%	2.2%	0.8%	3.7%	2.8%
State	3.1%	3.2%	0.7%	1.3%	2.5%	1.6%	2.3%	2.3%

Table 3C: Profit margin percentiles by region, FY 2006	25th percentile	50th percentile (Median)	75% percentile	Number of providers
Central (Baltimore & area)	-2.0%	2.0%	4.3%	39
East (Eastern Shore)	-1.9%	4.4%	6.5%	15
South (Washington suburbs & Southern tri-county area)	-0.1%	1.8%	4.5%	29
West (Western Maryland)	1.0%	2.8%	4.0%	17
State	-0.5%	2.3%	4.7%	100

4.3 Current ratio

The current ratio is an indication of how much cash and other liquid assets (receivables and marketable securities) a provider has available, as compared with their current liabilities, i.e., it is one indicator whether the provider has funds to pay its bills on time. Generally, the higher the ratio, the better the situation of the provider. The spread of the current ratio is shown in Table 4.

Table 4: Current ratio	1999	2000	2001	2002	2003	2004	2005	2006
75th percentile	3.4	3.1	3.5	3.3	3.1	3.3	3.2	2.6
50th percentile (Median)	1.9	1.4	1.8	1.7	1.8	1.7	1.7	1.4
25th percentile	1.0	1.0	0.9	0.9	1.1	1.0	0.9	1.0

The providers of community services reporting to DDA experienced an increase in their current

ratio from 1997 to 1999, a drop in 2000, and a recovery in 2001 that was stable through 2005, but with a drop in 2006.

FY 2006 median current ratio by region:

Table 4A: Current ratio	Central	East	South	West
Median	1.3	2.7	1.5	1.3

4.4 Days in cash and investments

Cash and investments are closely related to the current ratio. They represent money that is available to the provider in the short term. Cash and investments represented 28% of the total expenses. The cash and investments, thus, represent 102 days of expenses in FY 2006. Some of this cash may be restricted or allocated for specific capital projects and so may not be available for operations. Revenue from investments is often an important source of revenue for the providers.

Days in cash and investments is an important measure as it indicates a provider's ability to pay their bills, and to deal with delays or interruptions in their income stream. 45 to 60 days is a reasonable level. The higher the number of days of cash and investments the better.

4.5 Days in receivables

Receivables represented 12% of the total revenues (up from 10% the previous year), so providers had, on average, 46 days of revenue in receivables. Receivables are the total charges associated with bills that have been sent out, but not yet paid. The days in receivables measure the average delay in payment and 45 days is a reasonable level. The lower the number of days in receivables the better.

4.6 Bad debts

Bad debts do not appear to be an issue for the providers contracting with DDA. The majority of the providers reported no bad debts, and the total bad debts reported were only 0.4% of the total revenues, down from 0.6% the previous year. The low level of bad debt is understandable given the nature of the services provided and the fact that the State is the major payer for these services.

4.7 Net assets

Net assets are an important indicator of financial condition. The net assets are the total assets minus the total liabilities. Having negative net assets means that the provider has more liabilities than it has assets, and so is a major concern.

Of the community service providers reporting to DDA, 3 had negative net assets in FY 1999, only two had negative net assets in FY 2000, 7 had negative net assets in FY 2001, 3 had negative assets in FY 2002 and FY 2003, 6 had negative net assets in 2004, and 5 in 2005 and 2006. There is some difficulty in tracking the providers across years as the set of providers for which Audited Reports were available changed from year to year. The 3 with negative net assets in 2003 continued to have negative net assets in 2004, 2 with positive net assets in 2003 lost sufficient to turn their net assets negative in 2004, and the other provider did not report in 2003. 4 of the 5 providers with negative net assets in 2005 also had negative net assets in 2004. In 2005 and 2006 4 of the 5 providers with negative net assets were in the central region, and one was in the southern region. They varied in size.

Attachment 1: Definitions of terms

Total expenses: The total costs incurred by the provider during the year. These costs include labor, supplies, maintenance, contracts, depreciation of buildings and equipment.

Total revenues: The total payments received by the provider. These include payments from the state, payments from other payers, interest and investment income, donations.

Current assets: Assets that are available in the short term. These include cash, receivables, and marketable securities.

Total assets: All assets including the current assets, and long term assets such as buildings and equipment (after taking out accumulated depreciation).

Current liabilities: Payment due from the provider in the near future. These include payables and current mortgage payments.

Long term liabilities: Amounts due in the long term. These generally include mortgage payments (beyond the present year's portion) and other long term debt.

Total liabilities: The sum of the current and the long term liabilities.

Contributions: Revenue from contributions and donations. This includes United Way funding.

Cash and investments: Cash and investments reported in the assets section of the audited financial statement.

Receivables: The dollar amount of accounts receivable, as reported in the assets section of the audited financial statement.

Bad debts: Any amounts reported as being written off as bad debts or listed as bad debts in the Statement of Functional Expenses of the audited financial statement.

a significant percentage of the increased demand for residential services in the states today. The likelihood of older persons with developmental disabilities living into their own retirement and outliving their family caregivers has increased substantially in recent years. This has stimulated a growing demand for additional services and supports. The need to provide these services is frequently unanticipated by federal, state, and local agencies, often resulting in a crisis situation for families. It is an unfortunate reality that many family caregivers must die before the disabled relative for whom they are caring can receive services from the publicly financed system (Braddock, 1999).

Waiting Lists in the States

In 2003, 36 states reported that 51,131 persons with developmental disabilities were on formal state waiting lists for residential services, and not receiving services (Prouty, Smith, & Lakin, 2004). However, Prouty et al. (2004) estimated that 75,288 persons with ID/DD nationally were awaiting services (p. 39).

Some states maintain detailed waiting lists of service needs for persons with developmental disabilities. Some states do not officially collect data on the number of persons waiting for services, although state officials informally acknowledge that significant demand for services exists. Fifteen states (Alabama, Arkansas, the District of Columbia, Florida, Illinois, Iowa, Louisiana, Michigan, Minnesota, Mississippi, Ohio, Oklahoma, Tennessee, Washington, and Wisconsin) did not furnish waiting list data in the Prouty et al. study and six additional states indicated that their waiting lists were zero (California, Hawaii, Idaho, North Dakota, Rhode Island, and Vermont).

California does not maintain a waiting list, as services in California were considered an entitlement under the state's Lanterman Act. Hawaii eliminated its waiting list in 2000 as part of the settlement agreement in the *Makin et al. v.*

Table 18
PERSONS WITH MR/DD LIVING WITH AGING CAREGIVERS IN 2004[1]

State	Persons with MR/DD
Alabama	12,138
Alaska	796
Arizona	14,391
Arkansas	7,129
California	75,748
Colorado	8,756
Connecticut	9,305
Delaware	2,187
DC	1,233
Florida	59,866
Georgia	17,145
Hawaii	3,584
Idaho	2,910
Illinois	30,482
Indiana	14,417
Iowa	7,574
Kansas	7,010
Kentucky	10,526
Louisiana	10,110
Maine	3,365
Maryland	12,822
Massachusetts	17,027
Michigan	24,815
Minnesota	11,275
Mississippi	6,785
Missouri	15,201
Montana	2,410
Nebraska	4,648
Nevada	5,223
New Hampshire	3,075
New Jersey	22,734
New Mexico	4,478
New York	45,485
North Carolina	18,268
North Dakota	1,723
Ohio	30,220
Oklahoma	9,086
Oregon	9,351
Pennsylvania	37,228
Rhode Island	2,989
South Carolina	10,410
South Dakota	1,948
Tennessee	14,749
Texas	44,533
Utah	4,150
Vermont	1,580
Virginia	17,215
Washington	12,515
West Virginia	5,062
Wisconsin	12,636
Wyoming	1,199
United States	711,478

[1] Caregivers aged 60 years and older.

Source: Braddock, Hemp, & Rizzolo, Coleman Institute and Department of Psychiatry, University of Colorado, 2005.

State of Hawaii waiting list lawsuit. Hawaii's MR/DD spending increased 85% in inflation-adjusted terms from 1999 to 2004. In 1999, Idaho eliminated its waiting list when the legislature removed the "cap" on the projected number of Waiver participants. The number of Waiver participants increased from 474 in 1999 to 1,479 in 2004. The Wyoming legislature had increased allocations in 2000 to serve the 95 individuals awaiting services in the State at that time. However, in 2003, Wyoming reported that 22 persons awaited services (Prouty et al., 2004).

Lakin (1998) has noted that waiting list initiatives in the states have generally involved expanding family support to prevent or delay the need for placement, and obtaining new or reallocated resources from the following sources: institutions, ICF/MR conversion to HCBS Waiver programs, capping reimbursement for existing programs, or seeking additional Medicaid funding. Several states have begun to address the need for services in response to waiting lists.

New Jersey allocated an additional $11.7 million in the 2004 Division of Developmental Disabilities budget to open 84 additional group homes for over 400 individuals ("Funds released," 2003). In Kentucky, the Governor identified funding to serve an additional 500 persons on the waiting list ("Kentucky legislation," 2003) and community spending increased an inflation-adjusted 18% from 2002-04. In Massachusetts, full funding was received for the waiting list reduction and educational transition programs. This provided funding for 250 of the 375 placements required under the *Boulet* settlement ("Governor's budget maintains," 2003). Massachusetts' inflation-adjusted community spending advanced 3% during 2002-04. In New York, Governor Pataki recommended a $154 million ten-year additional commitment to the NYS-CARES II program ("New York makes new," 2003). The NYS-CARES II program, originally established for five years, was made a permanent part of the Office of Mental Retardation/Developmental Disabilities (OMR/DD) budget last year by the state General Assembly, acting on a request from Governor Pataki. New funding in the Governor's '06 budget for NYS-CARES II brings the total to $95.3 million ("Residential services expansion," 2005).

Current Litigation

During the 1970s and 1980s, federal class-action lawsuits were filed by advocates to improve conditions in public institutions in many states. In the late 1990s, three types of class-action litigation emerged in the states: lawsuits filed to compel states to expand services to people on waiting lists; lawsuits filed to compel states to meet the requirements of the *Olmstead* decision; and lawsuits filed on behalf of individuals who were eligible for Medicaid services that they did not receive. These lawsuits are identified in ***Table 19***, which presents the name of the case, the issue (waiting list, *Olmstead*, or access to Medicaid benefits); the disposition (i.e., settled, dismissed by the Court, trial scheduled or otherwise pending judgment); whether the judgment or settlement appeared to favor the plaintiff or the defendant; and the date the lawsuit was filed. As of May 2005, 22 waiting list lawsuits, 9 *Olmstead* lawsuits, and 15 Medicaid access lawsuits were active.

The identification of the 46 cases listed in ***Table 19*** was obtained from Smith (2005), who produces a useful periodic summary of "Litigation Concerning Home and Community Services for People with Disabilities." Additional information provided in our summary of current litigation was obtained from Kitchener, Willmott, and Harrington (2005); Priaulx (2004); and from the *Mental and Physical Disability Law Reporter* (various issues spanning May, 2003 to April, 2005).

Waiting List Cases

There are currently 22 active waiting list cases, including nine cases for which a judgment

or disposition was reached during 2002-05. Earlier waiting list litigation in Florida helped trigger these lawsuits (Smith, 2005). In *Doe v. Bush* (2001, filed in 1992), Florida was directed to develop a plan to serve 600 children and adults with developmental disabilities on the state's ICF/MR waiting list. The state was found to have a responsibility to provide services to Medicaid recipients with developmental disabilities with "reasonable promptness," which the court stipulated must occur within 90 days. The principal defendant in *Doe v. Bush*, the State of Florida, lost both in federal district court and on appeal in the Eleventh Circuit ("Waiting list suit," 1999). In *Brown v. Bush* (1999), another Florida case, the parties settled in April 2004, and the state agreed to close two of the remaining four state-operated institutions by 2010. The state also appropriated additional funding for the HCBS Waiver for fiscal year 2005 to serve individuals leaving the institutions for community settings (Priaulx, 2004).

In seven of the 22 cases with judgments reached during 2002-05, there was a clear benefit for the plaintiffs (Arkansas, Connecticut, Illinois, Maine, Oregon, and Tennessee (two cases). In Alaska and New Hampshire, the cases were dismissed with benefits for both plaintiffs and defendants. Of the remaining 13 open or pending waiting list cases, Kitchener et al. (2005) identified the following three cases in Illinois, New Mexico, and Pennsylvania as "important cases" (i.e., possibly precedent setting).

In Illinois, *Bruggeman et al. v. Blagojevich et al.* (2004) was filed September, 2000 by a private attorney in the U.S. District Court of Northern Illinois on behalf of five plaintiffs with developmental disabilities. The Court dismissed the case in February, 2002, denying the plaintiffs' main claim of lack of access to Medicaid ICF/MR and Waiver services near their families. Plaintiffs appealed to the Seventh Circuit Court of Appeals in March, 2002. In April 2003, the Seventh Circuit reinstated plaintiffs' claim and remanded the case to the District Court to consider whether the state had a plan oriented to preventing the isolation or segregation of persons with developmental disabilities pursuant to *Olmstead* (28:2 MPDLR 151). The U.S. Department of Justice submitted an *amicus* brief in June 2002 and another *amicus* was filed by the ACLU of Illinois, Equip for Equality (Illinois' Protection and Advocacy Agency), and by an Illinois coalition of Centers for Independent Living. In July 2004, the parties announced that they had arrived at a stipulated settlement, reportedly limited in scope to the provision of services to the five named plaintiffs. According to Smith (2005), the Court then dismissed the case.

In New Mexico, *Lewis et al. v. New Mexico Department of Health et al.* (2000) resulted in a judgment for plaintiffs in February 2004. The case was filed in January 1999 in the U.S. District Court for New Mexico by the state's Protection and Advocacy agency with support from The Arc of New Mexico. The class action suit was filed on behalf of people in private ICFs/MR, in the state institution (Los Lunas), or in the community who were seeking HCBS Waiver services. In February 2002, the court ordered the state to offer Waiver services as soon as they became available, and to provide Waiver services within 90 days of determining eligibility. In September 2004 the plaintiffs filed to hold the state in contempt, arguing that the state was not offering services up to the approved limit. In October 2004, the state pleaded that Waiver services can go only as far as funds are available. The state urged the Court to dismiss the plaintiff's new motion. This case is pending (Kitchener et al., 2005; Smith 2005).

In *Sabree et al. v. Richman* (2003), a Pennsylvania case, the plaintiffs were wait-listed for ICF/MR services and filed this non-class action case because of a proposed reduction of funds for the community services waiting list. The

Table 19
COMMUNITY SERVICES LITIGATION IN THE STATES: 2002-2005

	State	Lawsuit	Issue	Disposition	Favored?	Date Filed
1	Alabama[1,3]	*Sutton J. et al. v. Riley et al.*	waiting list	Suit is in the 11th	Pending	July 2005
2	Alaska[1]	*Carpenter et al. v. AK Dept. of Health & Social Services*	waiting list	Dismissed 3/02	Both	January 2001
3	Arkansas[1,3]	*Tessa G. v. Arkansas Dept. of Human Services et al.*	waiting list	Dismissed 8/03	Plaintiff	June 2003
4	Colorado[1]	*Mandy R. et al. v. Owens et al. (& access)*	waiting list	Appealed 3/04	State Pending	August 2003
5	Connecticut[1]	*ARC/Connecticut et al. v. O'Meara and Wilson-Coker*	waiting list	Settled 2/14/02	Plaintiff	October 2001
6	Florida[1]	*Wolf Preis-Sherman et al. v. Bush et al.*	waiting list	Received Ruling 3/04	State	2002
7	Hawaii[1,3]	*Disability Rights Center et al. v. State of Hawaii et al.*	waiting list	Settled at 1st Trial 7/04	Pending	Sept 03
8	Illinois[1,3]	*Brogerson et al. v. Blagojevich et al.*	waiting list	Settled 7/04	Favored Plaintiffs	
9	Kentucky[1]	*Michelle P. et al. v. Morgan et al.*	waiting list	Trial 8/04	Plaintiffs Favored	February
10	Maine[1,3]	*Ransom et al. v. ME Dept. of Human Services et al.*	waiting list	Settled 7/02	Plaintiff	August 2001
11	Nebraska[1]	*Bill M. et al. v. Dept. of Health and Human Serv.*	waiting list	State Appealed 8/04	State Pending	May 2003
12	New Hampshire[1,3]	*Durrenberg et al. v. Shaheen et al.*	waiting list	Dismissed 3/03	Both	January 2003
13	New Mexico[1,3]	*Lewis et al. v. NM Department of Health et al.*	waiting list	Judgment for Plaintiff 2/04	Pending	January 1998
14	Ohio[1]	*Martin et al. v. Taft et al.*	waiting list	Some Waiver 2/05	Pending	1999
15	Oregon[1,3]	*Staley et al. v. Kitzhaber et al.*	waiting list	Settled 1/04	Plaintiff	January 2003
16	Pennsylvania[1,3]	*Stamos et al. v. Houston*	waiting list	Appeal Issued Plaintiff 3/04	Plaintiff, Appeal 11/04	May 2002
17	Tennessee[1]	*Brown et al. v. The TN Dept. of Mnt and Dev. Dis. & Ramsyer*	waiting list	Settled 8/04	Plaintiff	July 2000
18	Tennessee[1]	*Ramsyer & People First of Tennessee v. Neal et al.*	waiting list	Settled 6/04	Plaintiff	March 2001
19	Texas[1]	*McCarthy et al. v. Hale et al.*	waiting list	Appeal Issued Plaintiff 2004, Trial	Pending	
20	Utah[1,3]	*D.C. et al. v. Bell et al.*	waiting list	Trial 1/05	Pending	Dismissed
21	Washington[1,3]	*Boyle et al. v. Braddock*	waiting list		Pending	Dismissed
22	Washington[1,3]	*The Arc of Washington State et al. v. Lyle Quasim et al.*	waiting list	Appeal for Stay 12/04/5	Pending	
1	California[1]	*Sophia Pepple Fehr et al. v. CA Dept. of Dev. Dis. et al.*	Dismissed	Appeal to Plaintiffs 3/05	Trial Pending	January 2002
2	California[1,3]	*Davis et al. v. CA Health and Human Serv. Agency et al.*	Dismissed	Settled 2/04		2002
3	Delaware[1,3]	*The Arc of Delaware et al. v. Meconi et al.*	Dismissed	Settled 8/04	Plaintiff	April 2002
4	Florida[1,3]	*Brown et al. v. Bush et al.*	Dismissed	$6M Settlement in on Appeal 12/04	Pending	1998
5	Hawaii[1]	*Mawi et al. v. State of Hawaii*	Dismissed	Settled 4/03	Plaintiff	
6	Massachusetts[1]	*Rolland et al. v. Romney et al.*	Dismissed	Appeal Issued Plaintiffs 1/03	Plaintiffs	October 1994
7	Montana[1,3]	*Travis D. et al. v. Eastmont Human Serv. Center*	Dismissed	Settled 2/04	Plaintiff	1995
8	Pennsylvania[1]	*Frederick L. et al. v. Dept. of Public Welfare et al.*	Dismissed	Plaintiffs Appeal 2/04	Pending	2001
9	Pennsylvania[1]	*PA Protection & Advocacy v. Dept. of Public Welfare et al.*	Dismissed	Appeal Issued Plaintiffs 2/04/5	Pending Ruling	
1	Arizona[1]	*Sac et al. v. Sheboss et al.*	Access	State Appealed 5/04	Pending	January 2003
2	Arkansas[1,3]	*Pediatric Spec. Care, Inc. et al. v. AR Dept. of HS et al.*	Access	Trial pending, state appealed 3/05	Pending, Pending	November 2004
3	Arkansas[1]	*Porter and Andrews v. Kincheon et al.*	Access	Court Ruled 11/04	Plaintiff	October 2003
4	California[1]	*Sanders et al. v. Johnson et al.*	Access		Dismissed	May 2000
5	Connecticut[1]	*Progreso et al. v. Wilson-Coker*	Access	Settled 12/03	Plaintiff	
6	Illinois[1]	*Bertand et al. v. Watson et al. (CILA)*	Access		Pending	
7	Kansas[1]	*Weishet, Inc. et al. v. Schalansky et al.*	Access	No TRO 1/04	State Pending	October 2003
8	Minnesota[1]	*Assn for Retard. Residents in MN et al. v. Goodno et al.*	Access	Dismissed 11/04	Plaintiff	May 2003
9	Minnesota[1]	*Mazzeman et al. v. Goodno*	Access	Settled 3/04	Plaintiff	April 2003
10	Montana[1]	*Sandy L. et al. v. Martz et al.*	Access	Pending	Pending	Sept 03
11	Ohio[1]	*Nordeus Thompson & Oh Prov. Res. Assn. et al. v. Hayes et*	Access	Injunction ruled 8/03	Plaintiff, Settled	June 2003
12	Oklahoma[1]	*Hulver et al. v. OK Health Care Authority et al.*	Access	Dismissed 11/03	Plaintiff	2003
13	Pennsylvania[1]	*Network for Quality MR Services in PA v. DPW*	Access	Dismissed 7/03	State	August 2003
14	Tennessee[1]	*Alsbaugh et al. v. Goetz et al. (TennCare)*	Access	Settled 8/03	Plaintiff	
15	Texas[1,3]	*Frew et al. v. Hawkins et al.*	Access		Plaintiffs	1993

Data Sources:

[1] Smith, S.A. (2005, May 2). See text.

[2] Kirchner, K., Wilmoth, M. & Hamrick, C. (2005, January)

[3] Prieux, E. (2004, September)

[4] Mental and Physical Disability Law Reporter (Illinois - 28:2 MPDLR 151; Arkansas - 28:4 MPDLR 518; Minnesota - 28:2 MPDLR 151 - Oklahoma - 27:5 MPDLR 751)

Compiled from the above sources by: Braddock, Hemp, & Rizzolo, Coleman Institute and Department of Psychiatry, University of Colorado, 2005.

court ruled that plaintiffs had no enforceable individual rights to services, and that "reasonable promptness" only applied to groups, not individuals. This decision, however, was reversed on appeal. The Circuit Court in May 2004 issued an opinion that led to the plaintiffs filing an amended complaint in November 2004. The case is pending (Smith, 2005).

Olmstead Cases

An "*Olmstead*-type complaint" was defined by Kitchener et al. (2005) to include cases which are: "(1) started, decided or closed after the *Olmstead* decision in 1999; and (2) primarily about community placement of institutionalized people and/or people at risk of institutionalization. The cases are likely to cite the *Olmstead* decision and/or the Americans with Disabilities Act" (p. 15).

There were nine *Olmstead* cases during 2002-05, four of which were closed (cases in Delaware, Hawaii, Massachusetts, and Montana). According to Kitchener et al. (2005), the litigation in Delaware and Hawaii were important cases. *The Arc of Delaware et al. v. Meconi et al.* (2002) was filed in the U.S. District Court for Delaware in April 2002 by nine individuals and joined by The ARC of Delaware, Homes for Life Foundation, and by Delaware People First. An April 2004 memorandum of understanding provided that the state would place additional institutional residents in the community and seek increased HCBS services. In August 2004, the court approved a settlement with the state agreeing to move persons out of the Stockley Center (the public institution), to fund new community placement options, and to add a new Waiver program to provide supports for persons who live with their families (Priaulx, 2004; Smith, 2005).

In Hawaii, *Makin v. Hawaii* (2000) was settled April 2000, with the state agreeing to increase the HCBS Waiver program by 700 persons during 2000 to 2003. However, the lawsuit *Disability Rights Center et al. v. State of Hawaii et al.* (2003) was filed when the Center became involved in the implementation of the *Makin* settlement. The Center filed the suit after determining that there were still 300 persons on the waiting list, due to the state failing to meet the needs of class members. Settlement discussions in the *Disability Rights Center* case are now ongoing and if parties do not settle, they will go to trial in July 2005. *Makin* was a class action for people at home wait-listed for the HCBS Waiver due to a lack of funding. The Court disagreed with the defense that plaintiffs were not qualified to use *Olmstead* because they were not institutionalized. However, the Court ruled that any waiting time was permissible once the Waiver reached the CMS-approved capacity. *Disability Rights Center et al. v. State of Hawaii et al.* is categorized in ***Table 19*** as a waiting list case (Kitchener et al., 2005; Smith, 2005).

Access to Medicaid Benefits Cases

From 2002-05 there were 15 states with active lawsuits seeking Medicaid services for individuals previously determined to be eligible for those services. (For a discussion of the recent ruling by the 9th Circuit in the *Sanchez* case, see p. 25.)

In Arkansas (*Pediatric Specialty Care, Inc. et al. v. Arkansas Department of Human Services et al.*, 2004), the Eighth Circuit affirmed the district court's decision enjoining the Arkansas Department of Human Services from changing the state Medicaid plan by removing its therapeutic and early intervention day treatment services until there was an impact study on the effects of terminating the programs. The Eight Circuit did not, however, affirm the district court's enjoining the Department from changing the children health management services program or moving such services "off-plan" (off the state's Medicaid plan) (28:4 MPDLR 515). The state appealed March 2005 and the case is pending (Priaulx, 2004; Smith, 2005).

Masterman et al. v. Goodno (2004), a Minnesota case, addressed the issue of "rebasing" of rates for community provider organizations that resulted in an uneven redistribution of funds to counties under the state's HCBS Waiver. Plaintiffs could pursue their claim that the rebase program violates the integration mandate of Title II of the ADA. The court required that the budgets of the individual named plaintiffs remain at the pre-base levels until the lawsuit was resolved (28:2 MPDLR 151). The case was settled in favor of the plaintiffs June 2004 (Smith, 2005).

In Oklahoma (*Fisher et al. v. Oklahoma Health Care Authority et al.*, 2002), the Tenth Circuit court ruled that the state's decision to stop providing medically necessary prescription medication for recipients in community-based Medicaid programs, while continuing to provide medications to institutionalized persons, violated the integration mandate of Title II of the ADA (27:5 MPDLR 781). The Tenth Circuit remanded the case to the district court and the parties settled November 2003 (Priaulx, 2004; Smith, 2005).

A case in Texas (*Frew et al. v. Hawkins et al.*, 2003) addressed physician-ordered Early Periodic Screening, Diagnosis and Treatment (EPSDT) services. On January 14, 2004, the U.S. Supreme Court unanimously reversed the Fifth Circuit Court's decision that had favored the state. The Court determined that Eleventh Amendment sovereign immunity principles did not bar a federal court from enforcing a consent decree that was agreed to by Texas officials. That consent decree was to settle allegations that the State had violated the rights of children by failing to meet Medicaid EPSDT requirements (28:1 MPDLR 19).

In addition to these waiting list, *Olmstead*, and access to benefit cases, there have been other significant developments related to the ADA that could have implications for people with developmental disabilities and the services that states fund for them. The Supreme Court ruled in February 2001 that suits attempting to recover monetary damages under the ADA from states are barred by the Eleventh Amendment (*Board of Trustees of the University of Alabama, et al., v. Garrett, et al.*, 2001). In May of 2002 the Supreme Court ruled in *US Airways v. Barnett* that the ADA's requirement that companies make "reasonable accommodations" for employees with disabilities does not preempt company seniority policies ("Supreme Court Again Narrows," 2002). However, the Supreme Court upheld Title II of the ADA as applied to states in suits by private parties seeking monetary damages for denial of access to the courts (*Tennessee v. Lane*, 2004). In this case an individual with a disability had been denied access to the courtroom. According to the *Mental and Physical Disability Law Reporter*, this decision was "the most important disability-related decision in 2004 (28:3 MPDLR 317).

As we reported in our previous study (Rizzolo et al., 2004), State Protection and Advocacy agencies operated under the rubric of the Federal Developmental Disabilities Assistance and Bill of Rights Act of 2000 have played key roles in stimulating community services development and funding in cases in Arkansas, California, Connecticut, the District of Columbia, Iowa, Maryland, Michigan, New Hampshire, New Mexico, New York, Ohio, Pennsylvania, Texas, Utah, Washington, and Wyoming. Protection and Advocacy organizations are currently participating in 15 of the waiting list cases, seven of the *Olmstead* cases, and three of the Medicaid access to benefit cases listed in *Table 19*.

VIII. SUMMARY AND CONCLUSION

In November 2002, the states were preparing their budgets for FY 2004 and contemplating mid-year cutbacks to balance their budgets for FY 2003. Raymond Scheppach, executive director of the National Governors Association, called the states' economic condition "the worst budget crisis states have faced since World War II" (Brownstein, 2002; Pear, 2002). States faced deficits totaling $53.5 billion for fiscal year 2004, representing 10% of the aggregate of

states' general fund budgets (National Conference of State Legislatures, 2003). The fiscal shortfalls exceeded 20% of state general fund budgets in Alaska, Arizona, California, and New York. Shortfalls were over 10% of budgets in nine other states and over 3% in 15 states.

What impact did the deteriorating general budget conditions in the states actually have on MR/DD spending? As discussed earlier in this monograph, 12 states reduced inflation-adjusted MR/DD spending during FY 2003, 13 states did so during FY 2004, and 11 states reduced spending during the two-year period FY 2002-04. In nationwide spending comparisons between the previous two-year period (2000-02) and the 2002-04 period of the current study, there were also substantial reductions in rates of spending growth. For example, nationwide MR/DD inflation-adjusted community services spending grew 17% during 2000-02, but 9% during 2002-04. Total MR/DD spending grew 12% during 2000-02, but only increased 6% during 2002-04. Growth in individual and family support spending was 38% during 2000-02, but declined to 15% during 2002-04. These examples are illustrative of the general trends discussed in this monograph and indicative of the impact of fiscal constraints on state government during 2002-04.

There are many other more concrete examples of fiscal impacts. During 2003 and 2004, Alabama closed the Wallace, Brewer-Bayside, and Tarwater Developmental Centers. Ohio is currently closing Apple Creek and Springview Developmental Centers. Montana closed Eastmont, New York closed Sunmount, Pennsylvania closed Altoona, and Wisconsin is closing the Northern Wisconsin Center. Institutional per diem rates declined in 16 states during 2002-04. To partially address an $8.1 billion deficit for the 2004-05 biennium, the Texas Legislature reorganized 12 existing health and human services agencies into four departments. They reduced Medicaid program rates, consolidated Waivers, and reduced adjusted MR/DD spending by 1.3% from 2002 to 2004. Spending for family support, supported employment and supported living in Texas was reduced by 24%, 18%, and 10% in adjusted terms.

However, total nationwide federal-state MR/DD Medicaid spending increased an inflation-adjusted 12% during 2002-04, comparing closely to the 14% increase during 2000-02. The decline in the rate of Medicaid spending growth was modest due to the implementation of enhanced federal medical assistance percentages benefiting the states during 2003 and 2004. Medicaid spending growth continues to be a very critical budget issue confronting state executives and legislatures (NCSL, 2005). Other notable findings of the study are summarized below.

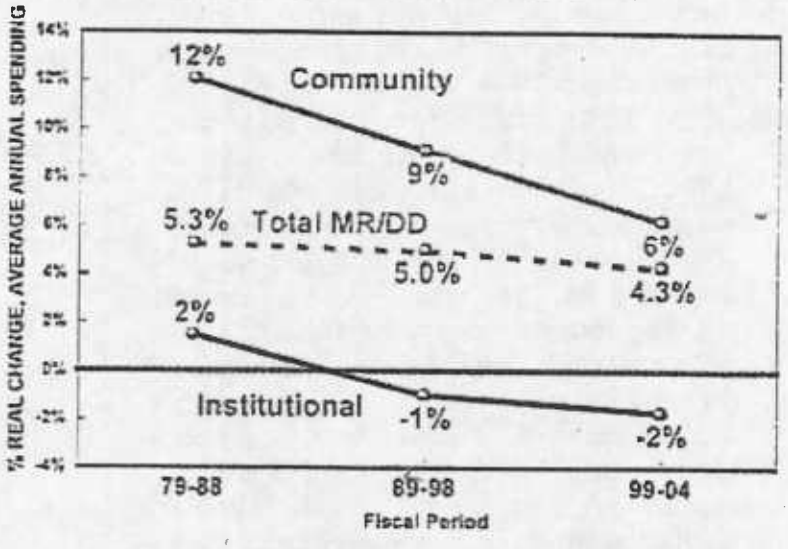
Public MR/DD Spending Growth Slows

Total spending for MR/DD services in the United States increased from $34.48 billion in 2002 to $38.55 billion in 2004. This inflation-adjusted 5.7% increase was the slowest rate of growth over any two year period in the history of our study (since 1977). In general, the overall rate of growth in public MR/DD spending in the U.S. remains robust, but the rate of growth has slowed in the past few years. Specifically, the average annual adjusted rate of growth of total MR/DD spending was 5.3% during 1979-88; 5.0% during 1989-98, and 4.3% during 1999-04 (*Figure 26*).

Annual adjusted growth rates in community services spending declined from 12% in the 1980s to 9% in the 1990s. The rate fell to 6% during 1999-04. Growth in community spending, however, remains substantially above the rate of inflation. The adjusted growth rate was 3.7% in 2003-04. In contrast to community spending, growth in public/private 16+ institutional services spending averaged only +2% in the 1980s, -1% in the 1990s and -2% during 1999-04. The public/private institutional sector is contracting.

Institutional Census and Spending Decline

Figure 25
AVERAGE ANNUAL PERCENTAGE CHANGE IN INFLATION-ADJUSTED MR/DD SPENDING: U.S.



Source: Braddock, Hemp, & Rizzolo, Coleman Institute and Department of Psychiatry, University of Colorado, 2005

Public/private institutional 16+ spending declined at least 10% in 14 states during 2002-04, and has essentially not increased in inflation-adjusted terms since 1991. Only one state committed more funding for 16+ institutions in 2004 than for community services. That state (Mississippi) has, however, also increased community spending for the past 10 consecutive years. The decline in spending for state-operated institutions throughout the U.S. is reflected in the rapid and continuing reduction of the residential census in the facilities. The census of state-operated institutions has declined from 2% to 7% every year since 1967, and now stands at 41,214 persons. State-operated institutions reduced their census by 3,237 persons during 2002-04, from a 2002 level of 44,451.

Utilization of all residential settings for seven or more persons, including nursing facilities, private 16+ institutions, state-operated institutions, and ICFs/MR and other group homes for 7-15 persons, also diminished. The 7+ residential care sector declined from 165,119 residents in 2002 to 157,278 residents in 2004, a reduction of 4.7%, and 7,841 persons. Settings for six or fewer persons grew from 308,225 persons in 2002 to 335,107 in 2004, an increase of 26,882 people. Most of this growth (81%) was in supported living, which expanded by 21,831 individuals.

Centrality of Medicaid: Challenges Ahead

The Medicaid HCBS Waiver remains the primary engine of growth in community services, particularly for supported living. Waiver participants increased from 365,679 in 2002 to 416,546 in 2004. Adjusted federal Waiver spending advanced 20%, from $7.6 billion to $9.2 billion. In contrast, federal ICF/MR program spending increased only 1% between 2002-04, from $6.6 billion to $6.7 billion. The number of persons with MR/DD residing in ICF/MR settings declined from 112,476 to 107,771 during 2002-04. The HCBS Waiver has also become the majority funding source for supported employment, family support, and supported living in the United States. Notwithstanding this fact, our study revealed a surprising plateau during 2002-04 in the number of participants receiving family support and supported employment.

Major challenges identified in this study include the continuing crisis in low wages and benefits for direct support staff despite an

apparent capacity to match additional Federal Medicaid funding in numerous states, including Connecticut, Oregon, Delaware, New Jersey, Ohio, Massachusetts, Virginia, California, and Illinois. Other significant trends apparent in this study include the growing influence of the U.S. Supreme Court's *Olmstead* decision promoting community living, the rising demand for services associated with increasing numbers of aging caregivers, the increased longevity of consumers requiring longer-term residential and community supports, and the continuing downsizing of public/private 16+ institutions and larger group homes.

In addition, a serious threat is on the horizon with respect to possible compromises to the integrity and solvency of the Medicaid program (Hemp & Braddock, 2003; Lambrew, 2005). This threat is accelerating as the nation's fiscal capacity is being challenged by rising domestic and defense expenditures and by significant fiscal challenges facing the states. In fact, the state funds component of Medicaid spending alone has increased from about five percent of total state spending in 1988 to 16.5% in 2003 (National Association of State Budget Officers, 2004). Medicaid spending (state match only) now exceeds financial commitments in the states for higher education, corrections, public assistance, and transportation. Only elementary and secondary education commands a larger share of total state spending.

In the short-term, the general fiscal outlook in the states is improving. The Rockefeller Institute of Government (2005) recently reported that aggregate state tax revenues during the July-March period of the current fiscal year (2005) were up 9.5% compared to the same three quarter period last year. State tax collections for the January-March 2005 period were up 11.7%, reportedly "the strongest first-quarter nominal revenue growth since at least 1991 (p. 1). Fiscal recovery in FY 2005 was particularly evident in California, with 17% growth over the previous 2004 period. The revenues in Alaska, Arizona, and New York grew by 40%, 17% and 10%, respectively.

The general improvement in the fiscal position of the states is attributable to enhancements in personal and corporate income tax revenues and, in some states like California, to growth in real estate taxes as well. Nevertheless, 31 states reported over-budget spending through March 2005 in some portion of their budgets, and 23 of these states identified rising health care costs, such as Medicaid spending, as a significant problem (National Conference of State Legislatures, 2005a). Medicaid funding is central to the financing of MR/DD services in the U.S., and any revisions to the Medicaid program need to be sensitive to the growing reliance of people with developmental disabilities and their families on this vitally important state-Federal partnership.

7. Q: What if there are general concerns about the SIS and its use? Questions about this Q & A information or Division Directives?
A: You can contact Steve Wrigley or Alan Tribble at the DSPD State Office by calling (801)538-4200.

8. Q: If the SIS shows a "need," does the team have to address it or fund it in the person's plan?
A: No, the SIS is only an assessment tool that will be used by the person's team to make planning decisions. The SIS identifies the intensity of support a person "needs" to be successful in a variety of activities. In some cases, this is very different than the identification of "needs" requiring a Waiver service/DSPD funding. If health and safety issues/ risk issues are identified, the team will want to make sure they have been adequately assessed and addressed in the plan as necessary.

9. Q: Will DSPD put out a Division Directive on SIS and Risk Assessment including clear timeline for implementation?
A: Yes, DSPD is currently working on a Directive that provides instructions/expectations for Support Coordinators. This is expected to be approved and in place by the end of February. The start date for implementation of the SIS was 1-1-06, so DSPD is now administering the SIS and Risk Assessment for all people in MR-RC and ABI services prior to their annual review/planning meeting.

10. Q: How will the Risk Assessment be used?
A: The Risk Assessment is an initial screening tool designed to identify issues for the team to assess/discuss. We want to catch issues that might not be known or that have been lost over time so the team can decide how they need to address the issue in the person's plan or even if they need to address it at all .

11. Q: In the Risk Assessment, why are different types of scores used (0,1,2 for some items and Type/Freq/Time scoring for other items)?
A: We are using some items from the SIS with their existing scores, so we do not need to repeat the same basic question and then we have added our own items to expand the assessment to cover some areas not addressed in the SIS. Section 4 has been created for Utah to include the items we have added and are scored the same way as Section 3. Because we are just trying to identify issues for additional assessment/discussion, this will not be problematic.

12.Q: Is this an unfunded requirement to provide staff time to be a respondent for the SIS (specific to Supported Employment)?
A: No, one staff's time can be reimbursed as they are with the client engaged in assessment activities. This replaces the ICAP as a part of the required assessment process.

<u>Support Coordinator Training/Issues:</u>
13. Q: How are Support Coordinators trained?
A: Steve Wrigley and Alan Tribble completed the SIS train-the-trainers course provided by AAMR and are providing the training for Support Coordinators and oversight for the SIS implementation. Support Coordinators training consisted of an initial 3 ½ hour training from Steve and Alan, practice, a second 3 ½ hours discussion/review and training on how to use the SIS in planning, follow-up training by DSPD Units including the electronic version of the SIS, Statewide Q & A phone conferences, and ongoing follow-up with SIS Region Coordinators and Unit Mentors.

14. Q: There are concerns about administration of SIS and providers seeing lots of variability. Are all Support Coordinators trained the same?
A: Yes, all have completed the same initial training but we are still doing follow-up. The SIS contains some complexities and subtleties that take time and practice to master. We may need a

couple more months to get everyone up to speed; however, we will continue to see a variety of administration methods as there is not only one right way to do it. We are training the general procedure as outlined in the SIS manual and supplemental materials, but this allows for flexibility We prefer to keep some flexibility unless we have a problem that we need to address with more rigid instructions.

15. Q: If DSPD sees a conflict of interest for providers to complete the SIS; why is it not a conflict for Support Coordinators too?
A: This seems to be mostly related to using the SIS for some funding related purpose and these decisions have not been made as addressed in question #3 above. In general, DSPD wants a neutral assessment that minimizes the potential conflict of interest that a provider might have in assessing the intensity of support needs for a person in their services. DSPD or Support Coordinators reimbursement from Medicaid or their actual salary is not directly or indirectly effected in anyway by the outcome of the SIS. Any money that might be saved by minimizing/reducing the costs of one person's services goes back to the providers through contracts in providing services for another person.

16. Q: If a provider is already doing the SIS, why not use theirs?
A: The primary reason is that DSPD has worked with AAMR to produce a unique SIS just for Utah containing elements not in the standard SIS. Also, there are considerations discussed in # 15 above. Additionally, DSPD wants to ensure the same standards for administration and scoring are used for everyone in services. DSPD is going to considerable lengths in training and oversight of the SIS. We believe limiting the administration of the SIS to only those DSPD Support Coordinators who have been certified in the SIS, will produce a reliable and valid SIS for every person in DSPD services.

17. Q: Can DSPD provide training for provider staff?
A: Steve and Alan have set up one training per Region for provider staff that will be involved in being an "respondent/informant" – what we need from them, how the assessment works, and just the practical stuff. We could help providers put together training materials if they are interested in conducting additional training; however, DSPD does not currently have plans for additional provider training.

<u>Sharing scores/raw data and reports:</u>
18. Q: Why do Support Coordinators not want providers to see scores/raw data? Is it best to describe it as the Support Coordinators own the SIS or the "team" completes it for the consumer?
A: The SIS is a DSPD tool completed by the Support Coordinator with information from the consumer and various other people who know them well (respondents). The Support Coordinator is trained to solicit information from the respondents and score each SIS items based on all available information. It might be misleading to say, "the team completes the SIS" as it is not a consensus type decision making process/activity. The team gives input and the Support Coordinator scores it. The Support Coordinator can discuss scores on items to generate discussion; however, they are not expected to share the final score recorded with the team. This is standard assessment practice and will speed up the assessment process considerably. We do not want to encourage extended debate over scores on individual items, that is not the way the SIS was developed.

19. Q: Of all the raw data and summary reports, what does provider get?
A: DSPD has worked with AAMR to produce two reports (a short and long report). Once the electronic SIS is operational, providers will be given a copy of the short report. The short report contains the standard SIS demographics, summary scores for Section 1, 2 & 3 with the graph for Section 1. We have added all the actual items with scores and notes for the Risk Assessment and a separate list of all items marked as most important "To &/or For" the person with scores and notes. This will provide the most important information for planning in an efficient report format.

The Support Coordinator will have access to the long report that adds all item scores and notes if there is a need for additional information on a specific item; however, we do not see a need to distribute the long form to providers at this time.

20. Q: If using the SIS for kids, do providers get some scores/raw scores? If not, they would only get to/for lists & risk information?
A: At this time we do not have a report format for children; however, we plan to give providers the same short report described in #19 above without the standard scores and graph.

21. Q: Can providers have access to SIS data, individual/aggregate? Just for their clients?
A: Individual data will be provided only in the reports described in #19 above. Individual or aggregate data will not be provided more directly until we have a data system with provider access. This is still very new and the USTEPS (DSPD data system) has not been deployed yet, so we really do not know at this time.

Reliability Issues:
22. Q: Do we need inter-rater reliability checks/data or other reliability assessment to prove DSPD has good reliability with the SIS?
A: DSPD will need to develop a methodology for assessing reliability to ensure trust in the SIS. We do not have a current plan for how best accomplish this need and we are currently focused on training and implementation integrity that will directly improve reliability.

23. Q: Can the Team involvement or consensus provide "trust" that scores are reliable or do we need inter-rated reliability assessed formally?
A: We do not think team consensus on a score adequately address reliability and see #18 addressing consensus scoring.

24.Q: Does DSPD think they can have adequate reliability on the SIS?
A: Yes, especially if providers cooperate by sending prepared staff to be respondents.

Logistics of Administration of SIS:
25. Q: Can the Division Directive on the SIS address scheduling the assessment with provider staff?
A: Yes, DSPD will set the expectation that all service providers will be invited to participate with a two week notice prior to the assessment.

26. Q: Who can give information as a respondent to SIS, sometimes it is a supervisor that knows the person best or can assist in getting the most accurate scores?
A: The SIS Manual says, "Respondent must have known the person being rated for at least 3 months and have had recent opportunities to observe the person in one or more environments for substantial periods of time (at least several hours per setting)." DSPD's expectation is that providers will follow this standard in choosing who will participate. In most cases, one staff that knows the person well from a provider will be adequate to be a respondent representing that agency/service. If a provider chooses to have a supervisor as a secondary respondent, DSPD requests that they also have direct knowledge about the person's support needs and that they allow the most knowledgeable staff to be the primary respondent.

27. Q: Does the consumer have to participate?
A: No, but it is preferable if at all possible and if it is a positive thing for them. There may be alternative methods to get information from a consumer who does not do well in structured/group meetings.

28. Q: Who has to be included, not included, can be included?
A: It depends; we want a small group who knows the person well (see # 26 and #27 above).

29. Q: Can some information be collected over the phone?
A: This is not ideal but is possible. This would be acceptable only if someone with unique information is unable to attend the assessment meeting and can be ask a limited number of questions at another time or over the phone, The expectation is that most assessments will be completed in a one-time assessment meeting with all respondents present.

30. Q: Does a provider need to provide information for all sections? (e.g. can a Supported Employment provider just answer employment questions?)
A: It is preferable to participate in the entire assessment meeting; however, this is not required. The SIS is not divided up in a way that a particular provider would only have interest or knowledge in one area. See #29 above for more information.

31. Q: Can SIS be done at the time of annual planning meeting?
A: This is not acceptable in any normal situation with a person already in services. The purpose of the SIS is to prepare for the planning meeting and the time requirements are not conducive to a quality assessment or planning meeting.

32. Q: Can DSPD Support Coordinators complete the SIS prior to the assessment meeting without respondents input?
A: According to the SIS Manual the interviewer (Support Coordinators) can complete the SIS without a respondent; however, the DSPD expectation is that the Support Coordinators only pre-complete a portion (less than half, if any) of the SIS that they are very confident is correct and that they review the entire SIS with the respondents for feedback and additional information. In some cases, pre-completion of a portion of the SIS can speed up the assessment without compromising quality.

An updated version of this AAMR - Supports Intensity Scale (SIS) Questions from Providers and Answers form DSPD document will be posted on the DSPD Website and will include additional items and clarifications as needed.
www.hsdspd.utah.gov

Supports Intensity Scale: What it is and how it can be useful

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SIS

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2004

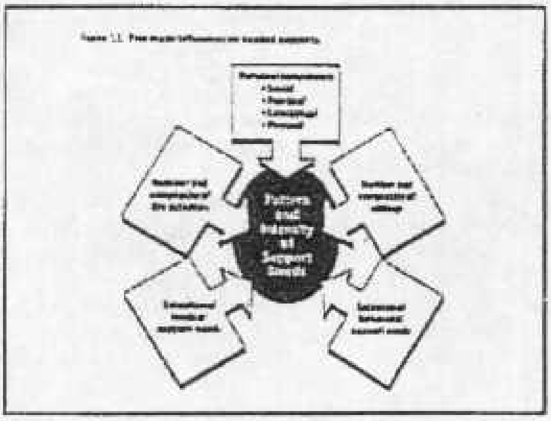
SIS

Defining "Supports"

Resources and strategies that promote the interests and welfare of individuals and that result in enhanced personal independence and productivity, greater participation in an interdependent society, increased community integration, and/or improved quality of life.

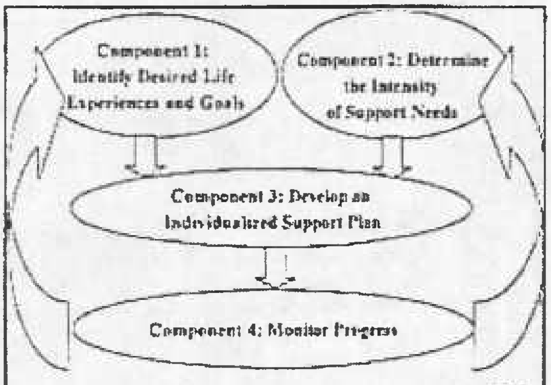
Supports are NOT limited to performance of a task; they also include training.

SIS



SIS – Support Needs and Assessment Planning Process

SIS



The Supports Intensity Scale

What is it?

A standardized assessment tool specifically designed to measure the pattern and the intensity of supports needed by an adult (16 years and older) with developmental disabilities.

- other assessment instruments provide indirect measures.

SIS

The Supports Intensity Scale

- Is NOT deficit based.
- Focuses on what supports are needed for the individual to be successful.
- The SIS is intended to assist planning teams in making clinical judgments regarding an individual's support needs.
- Is intended to be used as part of an support needs assessment and planning process.

SIS

Ratings on the SIS

Ratings should reflect the supports that would be necessary for this person to be successful in each activity.

Each item makes an assumption that the person has the opportunity to participate at levels potentially requiring maximum frequency, time, and type of support. Therefore, respondents should remember that ratings can reflect this maximum level of potential activity.

SIS

Definition of "Successful"

To be successful is defined as engagement in all aspects of an activity as judged against contemporary community standards and resulting in maximal involvement of the person in an activity. In other words, successful engagement entails a level of performance/involvement/participation in an activity that is comparable to that of typically functioning adults without disabilities.

SIS

SIS Administration

SIS is administered as a semi-structured interview by a qualified interviewer with preferably two or more respondents that know the individual well.

Respondent: the person himself/herself or someone who knows the person being evaluated for at least 3 months – recent opportunity to observe the person in one or more environments for substantial periods of time (parent, staff, job-coach, teacher, self).

SIS

SIS Administration

A qualified interviewer is a professional with experience in working with individuals with developmental disabilities. The Interviewer completes the SIS by obtaining information about the person's support needs via a semi-structured interview with two or more respondents. The interviewer should consult as many respondents as necessary.

Interviewer: professional (case manager, QDDP, psychologist, social worker, etc.).

SIS

The 3 Sections of the SIS

Section 2. Supplemental Protection and Advocacy Scale

Lists activities having to do primarily with self-advocacy against which an individual's support needs are rated in regard to frequency, duration, and type of support.

"What support does the person need to engage successfully in this life activity?"

SIS

The 3 Sections of the SIS

Section 3. Exceptional Medical and Behavioral Support Needs

This section contains "red flag" conditions or areas of support need with respect to health and behavioral problems that impact the person's overall level of needed supports.

"What is the significance of the following medical/behavioral conditions for this individual in regard to extra support required?"

SIS

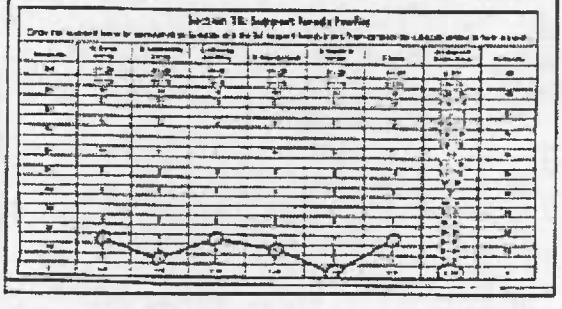
SIS SCORE FORM

SIS

SIS Scoring Form & Profile

Activities Subscales	Total Raw Score	Standard Scores	Percentile
A. Home Living	28	7	16
B. Community Living	23	5	5
C. Lifelong Learning	28	7	16
D. Employment	15	6	9
E. Health & Safety	6	3	1
F. Social	27	7	16
SUM of Standard Scores:		35	
SIS SUPPORT NEEDS INDEX		71	3

Support Needs Profile



SIS Scores

SIS

SIS Interview

- The interviewer should always ask him/herself

"What support does the person need to engage successfully in this life activity?"

SIS

Supports Intensity Scale

SIS

Supports Intensity Scale

- 3 Sections of the SIS:
  - Section 1. Support Needs Scale (49 items)
  - Section 2. Supplemental Protection and Advocacy Scale (5 items)
  - Section 3. Exceptional Medical (16 items) & Behavioral (13 items) Support Needs

SIS

The 3 Sections of the SIS

Section 1. Support Needs Scale

Lists an array of life activities against which an individual's support needs are rated in regard to frequency, duration, and type.

"What support does the person need to engage successfully in this life activity?"

SIS

Section 1. Support Needs Scale

6 Life Activity Areas (49 life activities):

A. Home Living Activities
B. Community Living Activities
C. Lifelong Learning Activities
D. Employment Activities
E. Health and Safety Activities
F. Social Activities

SIS

Section 2. Supplemental Protection and Advocacy Scale

RATINGS:

- Frequency (how often is the support needed)
  0 – 4 (< monthly hourly)
- Daily Support Time (when needed, how much time is required for the support)
  0 – 4 (None > 4hours)
- Type of Support (what is the type of support needed)
  0 – 4 (None Full Physical Assistance)

SIS

The SIS will provide an assessment of individual support needs

Section 1:

- PROFILE of 6 activity areas (Mean = 10; SD = 3)
- SIS Support Needs Index (Mean = 100; SD = 15)

Section 2:

- Supplemental considerations for Protection and Advocacy Activities

Section 3:

- Assessment of Support Considerations Based on Exceptional Medical and Behavioral Support Needs.

SIS

USEFULNESS OF SIS

SIS

Individualized Measure of Support Needs

- Profile of needed supports (Home Living, Community Living, Lifelong Learning, Employment, Health and Safety, Social) - together the six subscale standard scores provide a pattern of an individual's support needs;
- A SIS Support Needs Index (or composite standard score) is calculated from scores from the six subscales. It provides an overall indication of the intensity of an individual's supports needs;
- Support considerations based on Protection and Advocacy Scores;
- Support consideration's based on exceptional medical and behavioral support needs;
- Primary use: Basis for developing an Individualized Support Plan.

SIS

Individualized Measure of Support Needs

Although the Supports Intensity Scale (SIS) was developed primarily as a tool to assist with individualized supports planning, it does provide a direct measure of support needs that can be aggregated across comparable groups and agencies.

SIS

Potential Use of SIS Data

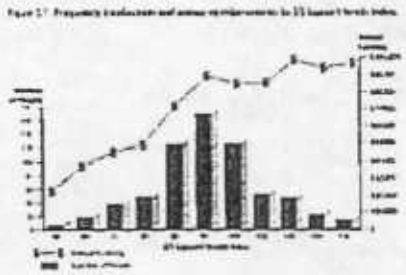
1. Inform Individualized Resource Allocation Models:

   (a) comparisons of levels of support needs predicted on the basis of the SIS with levels of supports actually provided;

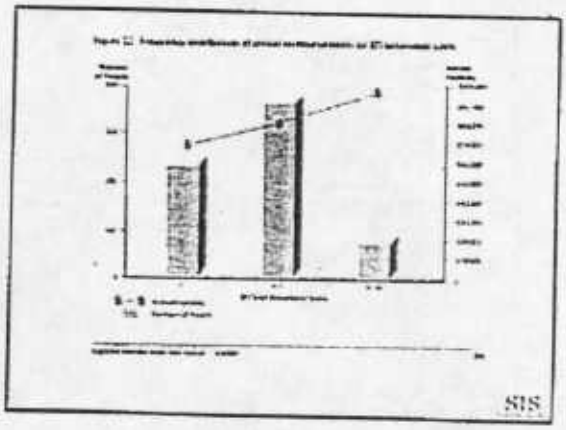
   (b) determination of inequities in reimbursement and funding patterns based on an individual's intensity of assessed support needs;

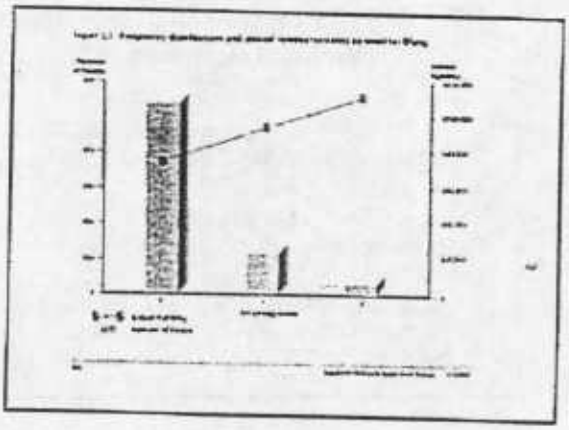
   (c) along with other personal/individual characteristics – provides a useful measure of a person-centered variable that can assist in explaining funding needs.

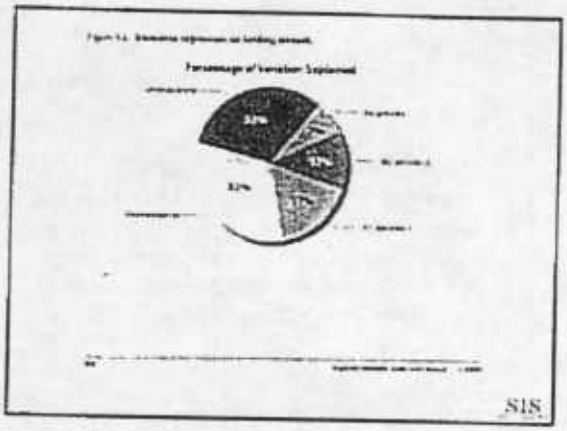
SIS



SIS







2

COMPARING SUPPORT NEEDS FOR INDIVIDUALS WITH COMPLEX NEEDS

SIS

SUPPORT NEEDS

- No Exceptional Medical Support Needs & No Exceptional Behavioral Support Needs;
- Exceptional Medical Support Needs;
- Exceptional Behavioral Support Needs.

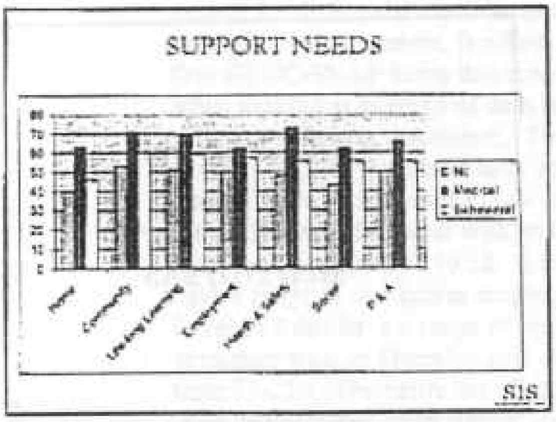
Compare:
- Intensity of support needs
- SIS INDEX
- Annual Cost

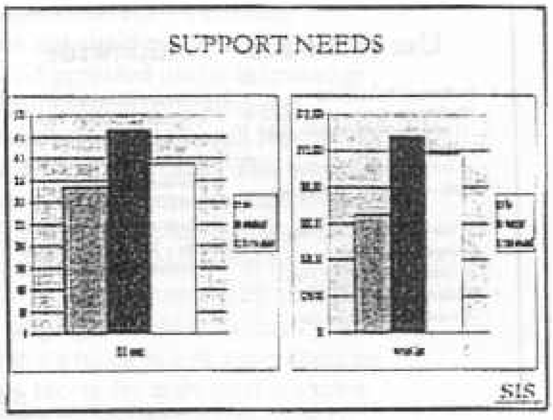
SIS

SUPPORT NEEDS

	(1) n=538 No Except. Supp. Needs	(2) n=39 Exceptional Medical	(3) n=285 Exceptional Behavioral
Age	41.9 (14.3)	42.3 (16.1)	40.4 (12.8)
Gender	46% female 54% male	46% female 54% male	45% female 55% male
Level IQ Deficits	>70 3% 51-70 37% 36-50 28% 20-35 23% <20 2% Missing 20%	>70 4% 51-70 8% 36-50 37% 20-35 28% <20 8% Missing 15%	>70 2% 51-70 21% 36-50 34% 20-35 31% <20 6% Missing 15%
Psychiatric Dx	23%	18%	17%

SIS





SUPPORT NEEDS

SIS Scales	(1) n=231 No Excep. Supp. Needs	(2) n=38 Exceptional Medical	(3) n=193 Exceptional Behavioral	Significant Differences (p > .01)
Home	39.9 (17.6)	63.4 (11.1)	43.1 (23.3)	1:2 2:3 1:3
Community	33.2 (18.2)	51.3 (11.3)	35.3 (34.3)	1:2 2:3 1:3
Life-long Learn	31.4 (28.6)	68.9 (22.9)	50.1 (17.3)	1:2 2:3 1:3
Employment	35.3 (31.7)	62.5 (21.3)	52.0 (11.3)	1:2 1:3
Health & Safety	47.9 (25.2)	72.9 (16.3)	55.4 (23.5)	1:2 2:3 1:3
Social	42.1 (22.3)	62.2 (21.6)	55.8 (19.2)	1:2 1:3
Prot. & Advoc.	30.2 (22.6)	45.9 (24.3)	35.3 (24.4)	1:2 2:3
SIS Index	253.3 (114.4)	466.1 (122.7)	346.5 (87.3)	1:2 2:3 1:3
Annual Cost	$65,066 ($51,478)	$107,760 ($70,751)	$96,103 ($54,385)	1:2 1:3

SIS

Section 3: PREVALENCE

Section 3A: Medical Supports Needed	0	1	2	
• Inhalation or oxygen therapy	84%	4%	12%	
• Postural drainage	85%	4%	11%	
• Chest PT	91%	8%	1%	
• Suctioning	82%	4%	14%	
• Oral stimulation or jaw positioning	77%	20%	10%	
• Tube feeding (e.g., nasogastric)	72%	6%	22%	
• Parenteral feeding (e.g., IV)	90%	2%	8%	
• Turning or positioning ***	30%	41%	32%	2
• Dressing of open wound(s)	62%	26%	12%	
• Protection from infectious diseases	92%	2%	6%	
• Seizure management	40%	30%	30%	3
• Dialysis	96%	2%	2%	
• Ostomy care	92%	2%	6%	
• Lifting and/or transferring	12%	41%	47%	1

*** = highest correlation with annual cost (all groups combined)

SIS

Section 3: PREVALENCE

Section 3B: Behavioral Supports Needed	0	1	2	
• Prevention of assaults/injuries to others ***	28%	53%	29%	2
• Prevention of property destruction	27%	48%	25%	3
• Prevention of stealing	39%	29%	33%	
• Prevention of self-injury	37%	43%	20%	
• Prevention of pica	94%	7%	5%	
• Prevention of suicide attempts	83%	12%	5%	
• Prevention of sexual aggression	76%	17%	7%	
• Prevention non-aggressive/inapp. behav.	48%	36%	16%	
• Prevention of tantrums/outbursts	6%	58%	36%	1
• Prevention of wandering	47%	33%	20%	
• Prevention of substance abuse	88%	6%	6%	

*** = highest correlation with annual cost (all groups combined)

SIS

SUMMARY

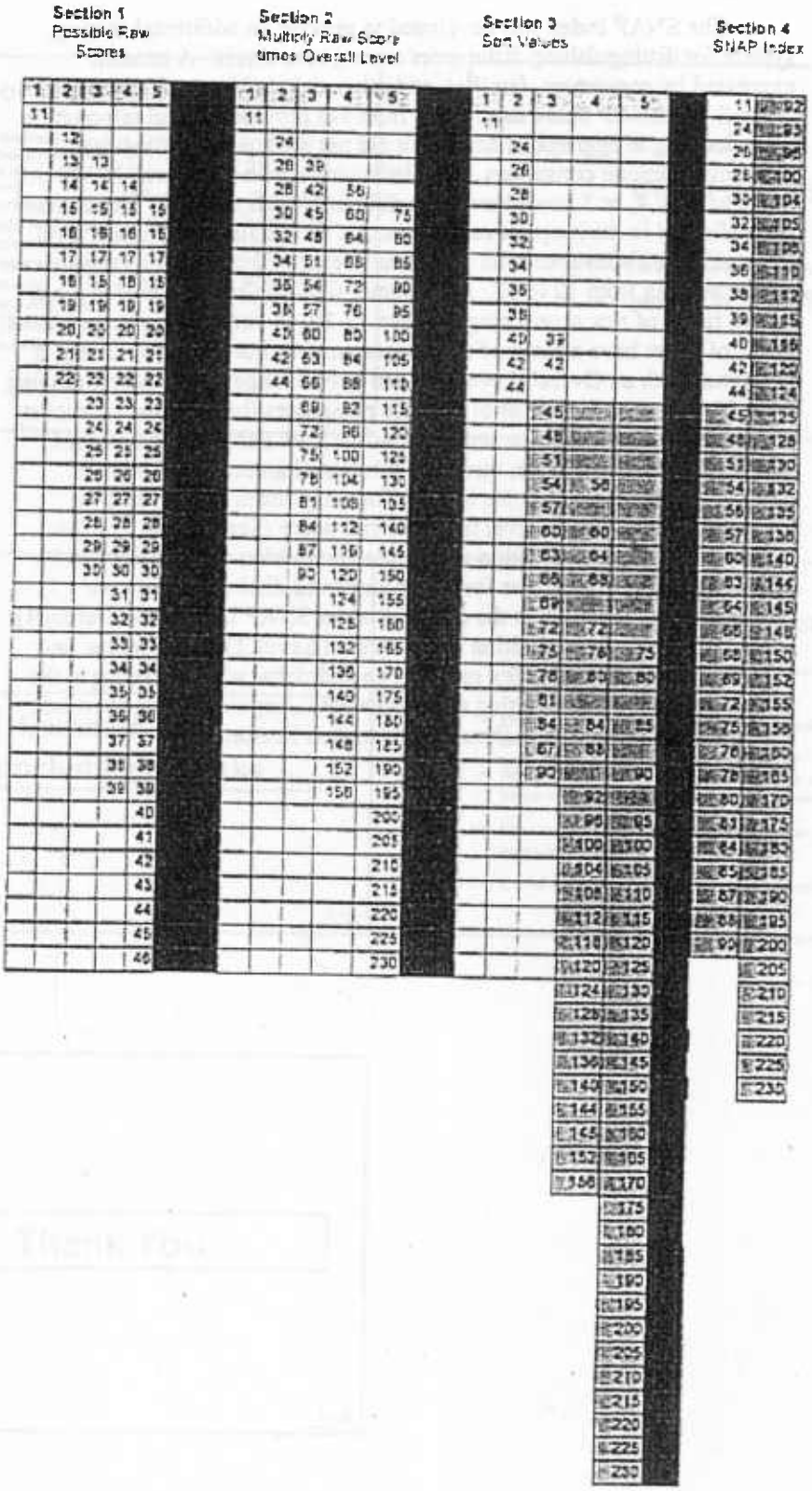
Individuals with complex needs = HIGH SUPPORT NEEDS

Exceptional Medical Support Needs = (turning and positioning) — HIGHEST SUPPORT NEEDS

Exceptional Behavioral Support Needs = (prevention of assaults) — EQUALLY HIGH COST

Cost to Agencies? Medical vs. Behavioral? (staff injuries / staff turnover, training, etc.)

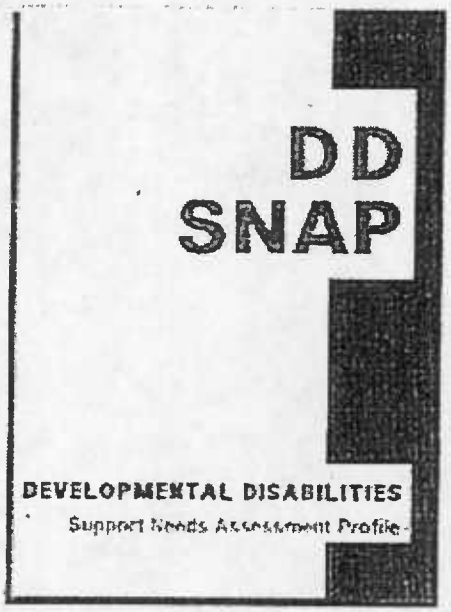
SIS


Section 1
Possible Raw Scores
Section 2
Multiply Raw Score times Overall Level
Section 3
Sort Values
Section 4
SNAP Index

Murdoch Center Foundation
919-844-3082

DD-SNAP

The Developmental Disabilities Support Needs Assessment Profile (DD-SNAP) is an assessment tool that can be used system-wide to consistently and reliably assess a person's level of intensity of need for supports and services. It was developed in response to a systematic need identified by the North Carolina Developmental Disabilities Policy Workgroup. The DD-SNAP is the result of three years and countless hours of work by numerous individuals involved in the North Carolina DD service system. The DD-SNAP is currently used in North Carolina and several other states.



DD-SNAP AUTHORS:

J. Michael Hennike
Aleck Myers
Tom Thompson
Rod Realon

FEATURES

- Easy to administer (average administration time is between two and twenty minutes).
- Measures need in three domains: Daily Living Supports, Health Care Supports, and Behavioral Supports.
- Uses a simple five point scale. View more...
- Ongoing reliability studies being conducted to insure inter-rater reliability.
- Training materials available including a video based examiners' curriculum.
- Accurate need profile information can be used to facilitate state-level planning of the DD Service Delivery system.
- The authors of the DD-SNAP include a team of psychologists with over 75 years of combined experience in the field of mental retardation.

EMPIRICALLY VALIDATED

- 1997: Initial field test (N = 553)

CLICK HERE
FOR PRICE and ORDERING
INFORMATION

- 1997-1999: Two year revision to improve predictive validity.
- 1999: Second field test conducted, stratified sample (N = 100).
- 1999 field test found to predict "good" or "ideal" support arrays in 70% of individuals.

[Home] [Up] [CONTACTS] [LEGAL ISSUES]

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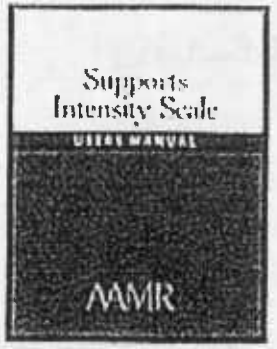
American Association on Mental Retardation

Supports Intensity Scale

Scott Meche, Ph.D.
Tammy Salter, M.S.

Based on original presentation by:
Marc J. Tasse, Ph.D.



Baton Rouge, LA
April 26, 2006

SIS
Supports Intensity Scale

SIS - Authors

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American Association on Mental Retardation
2004

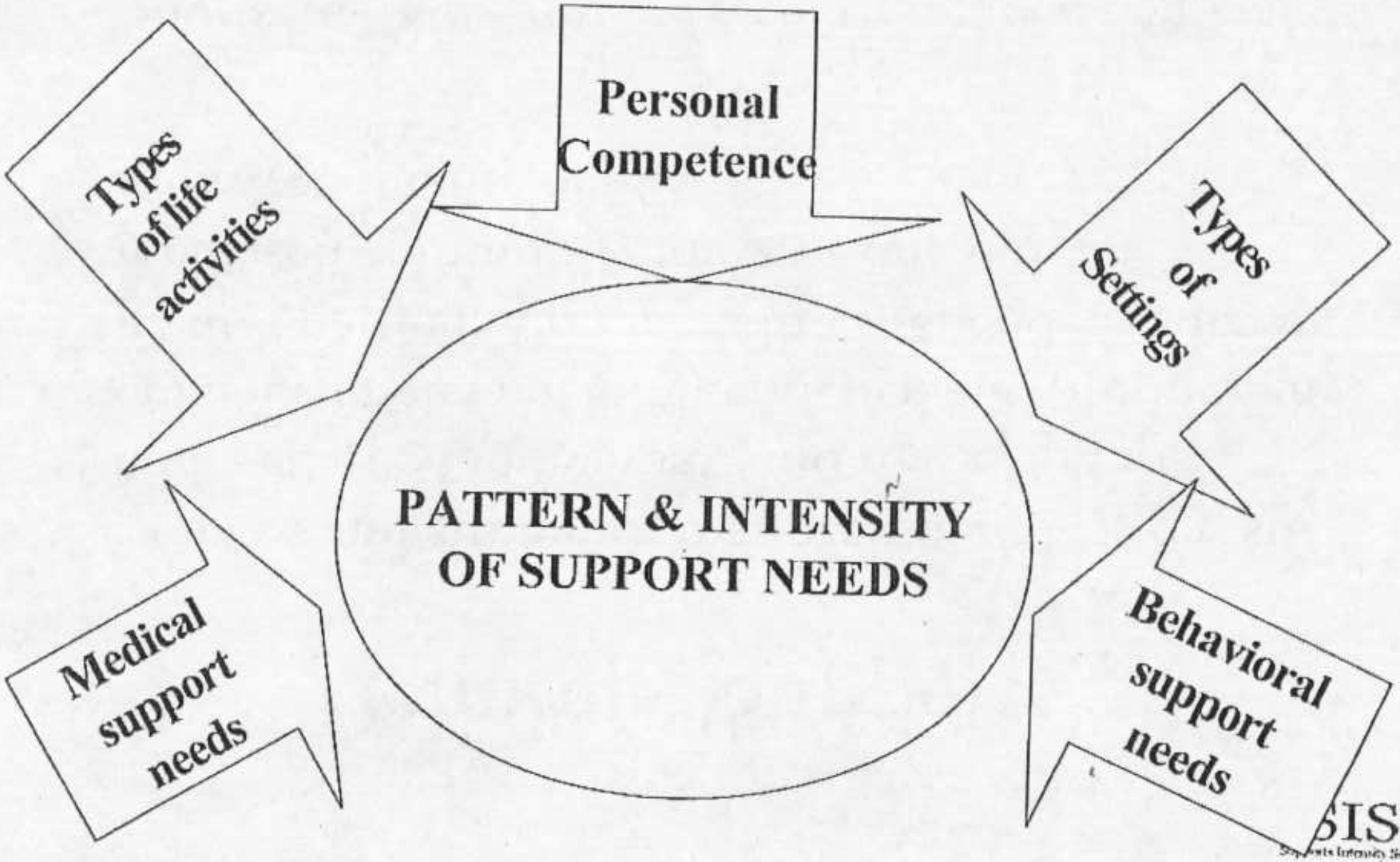
SIS
Supports Intensity Scale

Defining "Supports"

Resources and strategies that promote the interests and welfare of individuals and that result in enhanced personal independence and productivity, greater participation in an interdependent society, increased community integration, and/or improved quality of life.

Supports are NOT limited to performance of a task; they also include training.

Major Influences on Needed Supports



SIS
Supports Intensity Scale

Food for Thought

- Supports are needed and used by everyone.
- Assessment of support needs must start with the individual's needs and wants.
- Intensity of support needs will fluctuate over time, settings, situations.
- Supports help mitigate the "handicapping" effects of disabilities.

SIS
Supports Intensity Scale

The Supports Intensity Scale

What is it?

A standardized assessment tool specifically designed to measure the pattern and the level of supports needed by an adult (16 years and older) with developmental disabilities to be successful.

- Focuses on what supports are needed for the individual to be successful.

SIS
Supports Intensity Scale

The Supports Intensity Scale

- Is NOT deficit based.

- The SIS is intended to assist planning teams in making clinical judgments regarding an individual's support needs.

- Is intended to be used as part of an support needs assessment and planning process.

SIS Administration

- SIS is administered via a semi-structured interview with preferably two or more respondents who know the individual well.

- Respondents should be individuals who have known the person being evaluated for at least 3 months and have observed the person in one or more environments for substantial periods of time (parent, staff, job-coach, teacher, self).

Ratings

Ratings should reflect the supports that would be necessary for this person to be successful in each activity.

Supports Intensity Scale

- 3 Sections of the SIS:
  - Section 1. Support Needs Scale (49 items)
  - Section 2. Supplemental Protection and Advocacy Scale (8 items)
  - Section 3. Exceptional Medical (16 items) & Behavioral (13 items) Support Needs

SIS
Supports Intensity Scale

The 3 Sections of the SIS

Section 1. Support Needs Scale

Lists an array of life activities against which an individual's support needs are rated in regard to frequency, duration, and type.

"What support does the person need to engage successfully in this life activity?"

Section 1. Support Needs Scale

6 Life Activity Areas (49 life activities):

A. Home Living Activities
B. Community Living Activities
C. Lifelong Learning Activities
D. Employment Activities
E. Health and Safety Activities
F. Social Activities

RATINGS

- FREQUENCY
- DAILY SUPPORT TIME
- TYPE OF SUPPORT

SIS
Supports Intensity Scale

Section 2: Supplemental Protection and Advocacy Scale

This section is supplemental to Section 1.

Items focus on:

- Encouragement and acceptance
- Opportunity and access
- Exercising legal responsibilities
- Assisting with the acquisition and expression of skills

Each activity is scored with regard to Frequency, Daily Support Time, and Type of Support (as per Section 1).

Section 3: Exceptional Medical and Behavioral Support Needs

- This section consists of 15 medical conditions and 13 problem behaviors that typically require increased levels of support.
- The interviewer assesses the individual's intensity of support need for each medical and behavioral item using a 3-point scale (0 = no support needed; 1 = some support needed; 2 = extensive support needed).

Walkthrough of the Items
Section 1: Part A

Part A: Home Living Activities

1. Using the toilet
2. Taking care of clothes
3. Preparing food
4. Eating food
5. Housekeeping and cleaning
6. Dressing
7. Bathing and personal hygiene
8. Operating home appliances

SIS
Supports Intensity Scale

Section 1: Part B

Part B: Community Living Activities

1. Getting around in the community
2. Recreation & leisure
3. Using community public services
4. Going to visit friends & families
5. Participating in community activities
6. Shopping
7. Interacting with community members
8. Accessing public buildings & settings

SIS
Supports Intensity Scale

Section 1: Part C

Part C: Lifelong Learning Activities

1. Interacting with others in learning
2. Participating in educational decisions
3. Learning and problem-solving strategies
4. Using technology for learning
5. Accessing educational or training settings
6. Learning functional academics
7. Learning health and physical education skills
8. Learning self-determination skills
9. Learning self-management strategies

Section 1: Part D

Part D: Employment Activities

1. Accessing job accommodations
2. Learning & using specific job skills
3. Interacting with co-workers
4. Interacting with supervisors/coaches
5. Completing work on time
6. Completing quality work
7. Changing job assignments
8. Seeking information & assistance from an employer

SIS
Supports Intensity Scale

Section 1: Part E

Part E: Health & Safety Activities

1. Taking medications
2. Avoiding health & safety hazards
3. Obtaining health care services
4. Ambulating and moving about
5. Learning how to access emergency services
6. Maintaining a nutritious diet
7. Maintaining physical health & fitness
8. Maintaining emotional well-being

Section 1: Part F

Part F: Social Activities

1. Socializing within the household
2. Participating in recreation/leisure activities
3. Socializing outside the household
4. Making and keeping friends
5. Communicating with others about personal needs
6. Using appropriate social skills
7. Engaging in loving and intimate relationships
8. Engaging in volunteer work

Section 2: P & A

Protection and Advocacy

1. Advocating for self
2. Managing money and personal finances
3. Protecting self from exploitation
4. Exercising legal responsibilities
5. Participating in self-advocacy organizations
6. Obtaining legal services
7. Making choices and decisions
8. Advocating for others

SIS
Supports Intensity Scale

Section 3: Medical & Behavioral

Section 3A: Medical Supports Needed

- Respiratory care
- Feeding assistance
- Skin care
- Other exceptional medical care

SIS
Supports Intensity Scale

Section 3: Medical & Behavioral

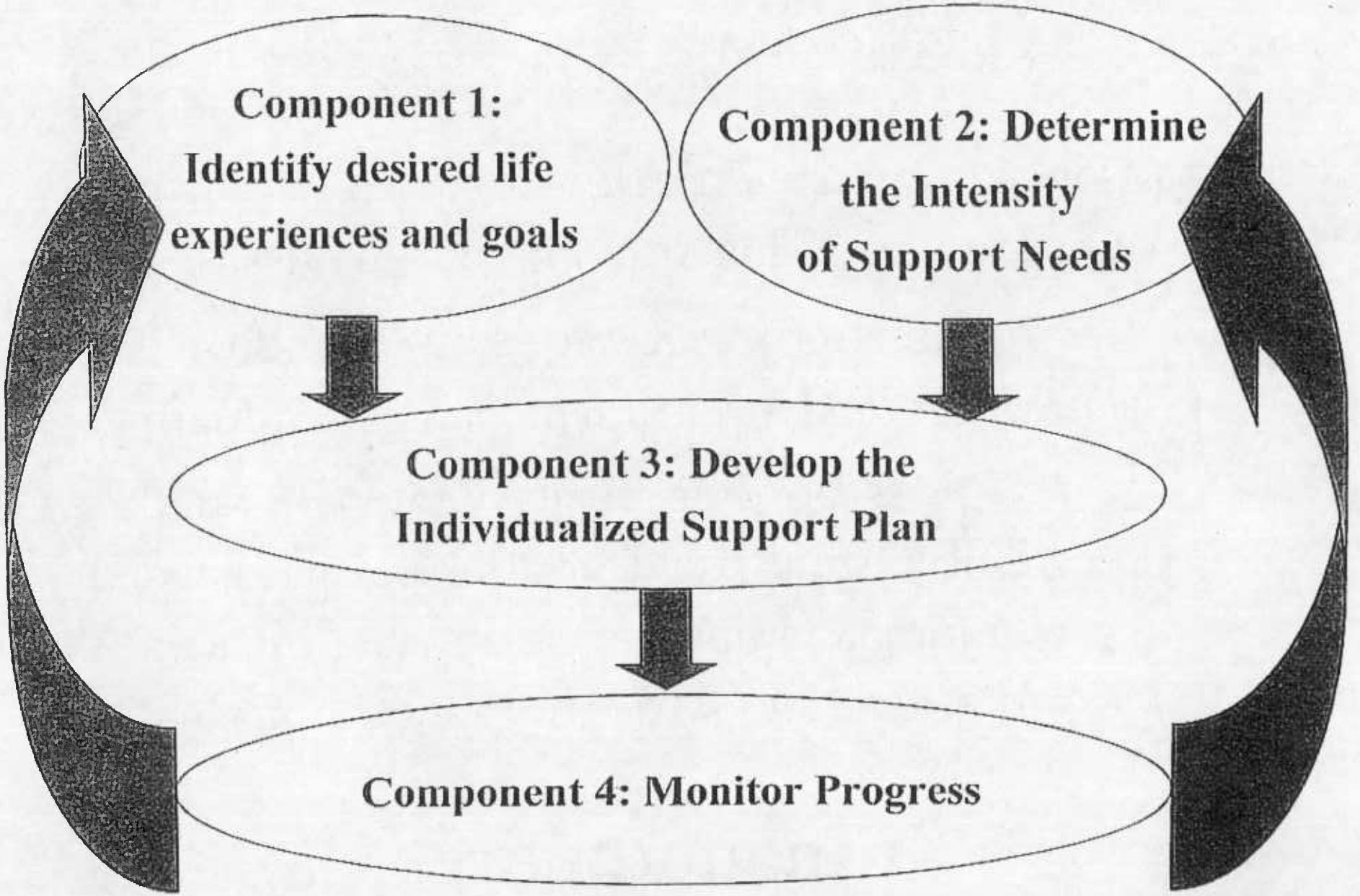
Section 3B: Behavioral Supports Needed

- Externally directed destructiveness
- Self-directed destructiveness
- Sexual
- Other

Building a Client's Individualized Support Plan with Information from the SIS and LA PLUS

SIS
Supports Intensity Scale

- Support providers, parents, family members and people with developmental disabilities can use the results from the SIS and LA PLUS to make decisions about the types and intensities of supports needed.
- Such decisions are best made within the context of a systematic planning and monitoring process that actively involves the person with a disability, family members, and other key stakeholders.



SIS
Supports Intensity Scale

Component 1

- This component involves identifying priority areas to be addressed when developing a personalized support plan. This requires a person-centered planning process.
- Identify lifestyle changes the person wants and current activities they wish to maintain.
- Assessments can identify supports needed to maintain or change priority activities as desired.

Component 2

- Information from the SIS and LA PLUS can be used in conjunction with the person-centered planning to guide a team to develop an individualized plan to achieve a person's desired goals.
- The Supports Need Profile is particularly useful to inform and guide a planning team to identify supports that should be introduced, maintained, or discontinued for an individual to achieve a valued lifestyle.

SIS
Supports Intensity Scale

Component 3

- Use SIS and LA PLUS results and information from person-centered planning to prioritize preferences and identify supports needed.
- Identify the support sources that are needed as well as those that are currently used.
- Write an individualized plan that specifies the pattern and types of supports needed to participate in specific settings and activities.

SIS
Supports Intensity Scale

The Benefits of Focusing on Support Needs in Individualized Planning

- First, the planning process shifts from fixing or changing the individual to identifying and designing supports that enable the person to participate in the community.
- Second, focusing on individual support needs is consistent with other facets of person-centered planning principles in that a deeper understanding of the person and his/her environment is gained.

SIS
Supports Intensity Scale

Component 4

- **Monitoring progress/Evaluation of individualized plan involves:**
- the extent to which desired life experiences and goals are being realized
- the extent to which desired life experiences and goals remain relevant
- the extent to which individualized plan was implemented

* Return to Components 1 and 2 as needed

SIS
Supports Intensity Scale

Continued

- Third, incorporating an evaluation of support needs into the planning process benefits the person, family members, and advocates.

  For example, by ensuring that diversity of major life areas are assessed the likelihood of overlooking an important facet of an individual's life is decreased.
- Fourth, it is important to systematically assess support needs to help address significant lifestyle changes identified in the person-centered planning process. The degree of specificity provided by the SIS and LA PLUS may help planning team members procure supports which an informal, global assessment may not reveal.

SIS
Supports Intensity Scale

Continued

- Because identified support needs are quantified, especially by the SIS, with respect to frequency, total daily support time, and type of support, changes in support parameters can be used to monitor and evaluate individual progress
- If desired lifestyle changes are not being achieved, the planning team can identify factors impeding success, introduce strategies to modifying supports received and continue to monitor everyday outcomes.

SIS
Supports Intensity Scale

Cautions in Relation to Planning

- First, SIS/LA PLUS data should not be viewed in isolation, rather they are part of a 4 component process of identifying desirable life experiences and goals, determining support needs, developing individualized plans and monitoring progress.
- Second, overreliance on scores and labels contradicts person-centered planning. Scores and classification terms facilitate communication but should never be used as a description of the individual since every person has unique characteristics. The person's individuality should be paramount in designing the plan of support.

Continued

- Third, though the SIS/LA PLUS may show a support need in a particular area, the individual or family may consider that a low priority and not want that addressed at that time.
- Fourth, prioritization of needs remains subjective and is based on desired goals of the individual and his/her family.

For more information about the SIS

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American Association on Mental Retardation

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Web site: www.siswebsite.org

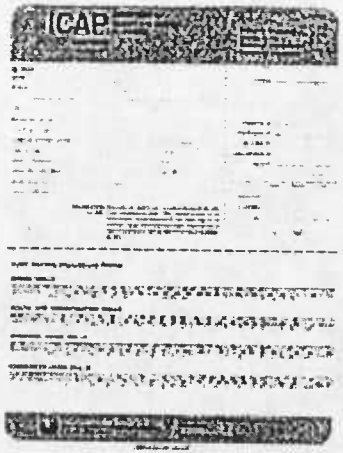
DADS - Access & Intake
Program Enrollment /
Utilization Review

ICAP

The Inventory for Client and Agency Planning (ICAP)

Level of Need (LON)

What is the ICAP?



The ICAP provides information about:

What a person can or can not do.

What kind of help a person may need to go about their daily living.

Why use the ICAP?

To determine the level of supports and supervision an individual might need to address his needs including behaviors.

DADS requires the use of the ICAP.

When Should The ICAP Be Completed?

- At intake
- Every three years
- More often as needed

Completing the ICAP

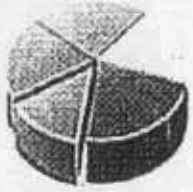
Front page

Descriptive information

Diagnostic status

Functional limitations and needed assistance

Completing the ICAP
Adaptive Behavior



4 DOMAINS

Motor Skills

Social and Communication Skills

Personal Living Skills

Community Living Skills

Completing the ICAP
Adaptive Behavior

Focus of this section :

Does (or *can)* the consumer do the task *completely* without help or supervision?

Completing the ICAP
Scoring of Adaptive Behavior

3 = Does task very well (independent)

2 = Does task fairly well

1 = Does task, but not well

0 = Never or rarely performs task

TIPS
Adaptive Skills Section

ICAP is Developmentally Based

Read each question carefully, but don't overanalyze

Rate individual's daily performance

Extensive refusal can affect scoring

Completing the ICAP
Problem Behavior Section

<u>8 Categories</u>

- Hurtful to self
- Hurtful to others
- Destructive to property
- Disruptive behavior
- Unusual/repetitive habits
- Socially offensive behavior
- Withdrawn or inattentive behavior
- Uncooperative behavior

Completing the ICAP
Problem Behavior Section

These behaviors impact or interfere with a person's day to day activities or with the activities of those around him or her.

In the applicable category:
List primary problem
Rate frequency
Rate severity

Completing the ICAP
Scoring of Problem Behavior

0 – Not serious, not a problem

1 – Slightly serious, a mild problem

2 – Moderately serious, a moderate problem

3 – Very serious, a severe problem

4 – Extremely serious,
a critical problem

Tips
Problem Behavior Section

Only ONE behavior in any section

Cluster behaviors are a single problem

Same or similar type behaviors should not be noted in more than one category

Moderately Serious must be formally addressed

Tips
Problem Behavior Section

Very & Extremely Serious = Behavior Plan

Behaviors must be discussed and documented

Inability to learn, developmental delay, medical condition, inconvenience

Tips

Problem Behavior Section

Consistent with other documentation

Actual/attempted occurrences,
NOT potential problems

Completing the ICAP

Sections F, G, H, and I

Residential Placement – current residence and any changes projected for 2 years

Daytime Program – current and any projected changes

Support Services – those provided and those needed.

Social and Leisure Activities –current activities and any limiting factors

Completing the ICAP

<u>General Information and Recommendations</u>

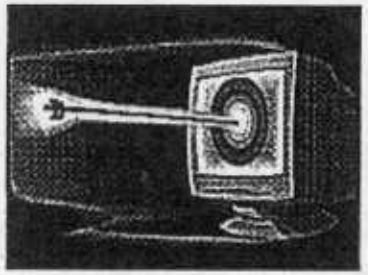
used to summarize information from other sources

<u>Summary of Scores:</u>

used to manually calculate the ICAP

Computerized Scoring

We suggest getting the computer scoring program for the ICAP.



Level of Need

What is a Level of Need?

- The Level of Need (LON) indicates level of assistance and supervision required
- Reimbursement for certain services in certain programs based on LON

Calculating LON
HCS • TxHmL • ICF/MR

LON	Description Of Support Needed	ICAP Service Level	Service Score Range
1	Intermittent	7, 8, or 9	≥70
5	Limited	4, 5, or 6	40 – 69
8	Extensive	2 and 3	20 – 39
6	Pervasive	1	1 – 19

LON 9

Pervasive Plus

Any ICAP Service Level

Any Service Score Range

Life Threatening Behaviors

Increases in LON

- LON increase due to ICAP change
- LON Behavior Increase
- LON 9
- LON Medical Increase (ICF/MR only)

ALL INITIAL LON PACKETS MUST INCLUDE:

Cover Sheet

Cover letter (optional)

ICAP booklet & scoring

Latest PDP/ISP/staffing & interims

Current and relevant documentation that supports your LON request

Additional Documentation for ICAP Change

- Discussion of what caused the change in skills and/or behavior
- Assessments that support new ICAP ratings
- New & old ICAP booklet and scoring
- Relevant incident, injury, restraint reports

Additional Documentation for Behavior Increase

- Current Behavior Plan (BMP, BSP, IBP), behavior data (including narratives), & progress notes
- Relevant incident, injury, restraint reports
- Current Psychological and/or Psychiatric evaluations
- Documentation of additional staff resources needed to manage the individual's behavior

Documentation needed for Renewal of Behavior Increase

- Level of Need (LON) Review/Increase Cover Sheet
- Cover letter addressing:
  - Individual's continued need for added staff to address the dangerous behavior(s)
  - Continued provision of additional resources by the provider due to behavior
- Current Behavior Plan

Additional Documentation for Level of Need 9

- BMP must include plan to fade 1:1 staff
- BMP monitoring notes
- Relevant incident, injury, restraint reports
- Staffing pattern in residence & day program (include 1:1 time sheets for 2 months)

Documentation needed for Renewal of LON 9

- Level of Need (LON) Review/Increase Cover Sheet
- Cover letter addressing:
  - Individual's continued need for 1:1 staff to address the extremely dangerous behavior(s)
  - Continued provision of 1:1 staff by the provider due to behavior
- Current Behavior Plan

Additional Documentation for a Medical Increase (ICF-MR Only)

- Supporting documentation indicating why 181 minutes or more of Nursing services per week are required.
  - Any pertinent and current professional assessments and other documents to support nursing services needed.
  - Nursing assessments and narrative notes
  - Physicians assessments and orders
  - Medication and treatment records

Additional Documentation for a Medical Increase (ICF-MR Only)

➢A completed Medical Increase Worksheet – ICF/MR Only (Form 8658 - obtain from DADS website)

➢This form prompts you for all the necessary information that must be included in a medical increase packet

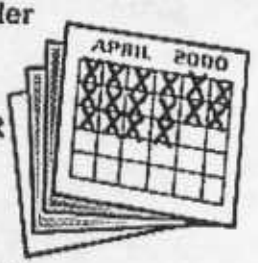
Documentation Required for a Medical Increase Renewal (ICF-MR Only)

Level of Need (LON) Review/Increase Cover Sheet
Cover letter addressing:
- Individual's continued need for direct nursing services >180 minutes per week
- Continued provision of needed services by a licensed RN or LVN

Completed Medical Increase Worksheet – ICF/MR Only (Form 8658)

LON Packet Time Lines

LON Change entered into Care by Provider



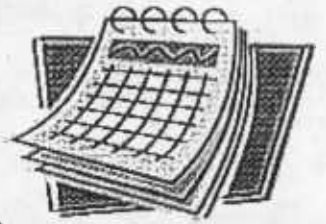
Within *7 calendar days*
- LON packet must be received by PE/UR

Within *21 calendar days*
- PE/UR completes LON review
-requests additional information as needed
-approves or denies LON change

Within *10 calendar days* (of receipt of Denial letter)
- reconsideration request received by PE/UR

LON Packet Time Lines

continued....



Within *21 calendar days*

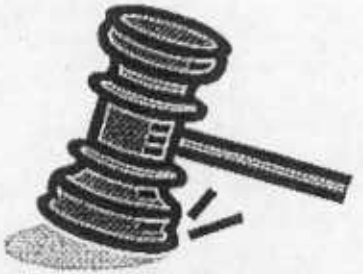
- PE/UR reviews reconsideration

- approves or denies

Within *15 calendar days* - (of receipt of denial letter)- provider may request Administrative Review

Administrative Hearings

- Legal proceeding presided over by a judge
- PE/UR will have legal representation
- Always held in Austin



Where can I find more information?

Website Addresses (continued)

ICAP Information: (Currently unavailable)

Guide for completing ICAP web page:
www.isd.net./bhill/guide.html

ICAP web page:
www.cpinternet.com/~bhill/icap/ (e-mail link)

Where can I find more information?

Website Addresses

DADS web pages:
http://www.dads.state.tx.us/providers/
(links to LON, contact, & all other information you might need)

Inventory For Client and Agency Planning

CATEGORIES: Behavioural, Clinical

AUTHORS: Robert H. Bruininks, Bradley K. Hill, Richard F. Weatherman, Richard W. Woodcock

RANGE: Infant to Adult

TIME: 20 minutes

SUMMARY

ICAP is a short, easy to use, standardized assessment instrument that measures adaptive and maladaptive behaviour. Its strong psychometric properties make it a valuable tool for determining eligibility, planning services, evaluating, reporting progress, or using in funding reports. Inventory areas include diagnostic and health status, functional limitations, adaptive and problem behaviour, residential placement, daytime program support services, and social/leisure activities.

The *ICAP* provides valuable information about an individual's ability to function in these general areas:

- motor skills
- personal living skills
- community living skills
- broad independence

In addition, information about the individual's maladaptive behaviours measured in terms of the frequency and severity of the problem can be obtained. There are eight categories of problem behaviours organized into four areas:

- internalized maladaptive index
- externalized maladaptive index
- asocial maladaptive index
- general maladaptive index

Uses of the *ICAP* include program and evaluation:

- secondary transition testing
- eligibility determination for service
- including home- and community-based services

Features of the *ICAP* include:

- nationally standardized on more than 1,700 subjects
- scores obtained include behaviour indexes and service level

Journal on Developmental Disabilities, Volume 11 Number 2

The Experience of Using the Inventory for Client and Agency Planning (ICAP)

Anna M. Palucka and Soula Homatidis

Abstract

When working with a client with dual diagnosis (i.e., developmental disability and mental health problems), it is often desirable to use a standardized instrument to gauge the level of support the individual requires. Although there is an overall paucity of such instruments, the Inventory of Client and Agency Planning (ICAP) is specifically designed to estimate the level of support required based on: a) the individual's level of functioning in a number of areas, and b) the presence/absence of maladaptive behaviours. This study was undertaken to describe the functional status and support needs of the clients seen for extensive outpatient consultation at the Dual Diagnosis Program at the Centre for Addiction and Mental Health in Toronto, Canada. The results are discussed in the context of issues related to the administration of the instrument and the duality (developmental and psychiatric) of the challenges that are encountered by individuals and professionals alike. The findings with respect to the discrepancy between actual and required levels of support shed some light on the ongoing struggle of the community to meet the needs of individuals who are dually diagnosed.

It is important for a program that provides clinical service to be able to describe the population served in terms of relevant characteristics to identify referral trends and plan for the provision of future services. The Dual Diagnosis Program at the Centre for Addiction and Mental Health in Toronto, Canada recently introduced an admission assessment package – the Inventory of Client and Agency Planning (ICAP) – to obtain relevant clinical/functional information on the clients referred as well as to assist in evaluating the effectiveness of subsequent interventions.

index

COMPONENTS

COMPONENTS	ISBN	PRICE (Cdn. $)
Complete Program (includes Examiner's Manual, 25 Response Booklets)	9-22160	$276.50
Response Booklets (Pkg. 25)	9-21900	$118.25

Prices are in effect October 1, 2005.

Compuscore for the ICAP (Bradley K. Hill, 1999)

This program runs on Windows 95/98/NT (8 MB free RAM, 4 MB free hard disk space). As there is an enormous amount of information contained in this new version, it is more easily accessed via a CD ROM. New features include:

- Online manual for easy access when questions arise
- Printing capability on network and Windows printers
- Launches to a word processor
- All reports can be saved to a file
- Datafiles are not limited to 9,999 clients
- Imports existing datafiles from Version 1.1
- Y2K compatibility

COMPONENTS	ISBN	PRICE (Cdn. $)
Compuscore for ICAP, Windows Version 2.0	9-22884	$471.00

Prices are in effect October 1, 2005.

top

One of the mandates of this relatively new program is to identify gaps in service delivery and advocate for the needs of individuals with dual diagnoses. The level of support that these individuals require is an ongoing question. Community care providers in the developmental sector and those in the mental health sector frequently have divergent views about the needs of this population. In addition, the community often feels ill-equipped to manage the many challenges with which these clients are confronted, and turns to hospitals (general and psychiatric) in the belief that these facilities can have a significant impact on their client's presentation.

The present study had two purposes. The first was to summarize the information obtained with the ICAP to describe the clients referred for outpatient consultation with respect to adaptive and maladaptive functioning. The second purpose was to gain an estimate of the level of support needed by these individuals in order to determine whether or not they are under-supported.

Method

Clients with a dual diagnosis referred for consultation service to the community-based team were administered the ICAP as part of the assessment package. The ICAP was completed by interviewing a care provider who knew the referred client well.

The ICAP (Bruininks, Hill, Weatherman & Woodcock, 1986) is a structured instrument developed from the Scales of Independent Behavior (Bruininks, Woodcock, Weatherman & Hill, 1985) to assess the status, adaptive functioning and service needs of clients. The instruments share the same norming sample.

The results were analyzed with respect to: 1) level of adaptive functioning, 2) seriousness of maladaptive behaviours, and 3) match between the actual level of support and level of support recommended.

Results and Discussion

Characteristics of Clients

In total, 18 clients were administered the ICAP as part of the assessment process, 10 males and 8 females. Their ages ranged from 18 to 52 years with the mean age of 33.8.

The majority of clients functioned in the mild (38.8%) or moderate (33.3%) range of intellectual disability (ID). Two clients were at the borderline level (11%) and two were at the severe level of ID. For one client the level of ID was unknown.

With regard to psychiatric diagnosis, more than half of the clients (61%) were diagnosed with a psychotic illness. The second most common psychiatric diagnosis was mood disorder (17.7%). Four clients had a diagnosis of autistic spectrum disorder.

Adaptive functioning

The Broad Independence Index was used as an overall measure of adaptive functioning. This index comprises four domains of independent functioning: motor skills, social/communication, personal living and community living skills. Results expressed as developmental age indicate a wide range of functioning ranging from 1.7 years (profound range of ID) to 11.6 years (mild to borderline range of ID), with the mean developmental age of 5.8 years.

Maladaptive behaviours

The General Maladaptive Index was used as an overall measure of maladaptive behaviours, encompassing both the severity and frequency of problematic behaviours that can be further classified as internalized, externalized or asocial. Exactly half the clients displayed serious maladaptive behaviours and another 17.7% had moderate maladaptive behaviours. For the remaining clients (33.3 %), the level of maladaptive behaviours was classified as marginal or normal. None were classified as very serious, despite the need for involuntary inpatient hospitalization and/or breakdown of service in a number of cases. One possible explanation for this finding is that this maladaptive behaviour index may underestimate the seriousness of behavioural problems if they are episodic in nature and/or occur in one or two areas. In addition, it is possible that some respondents may downplay the seriousness of the behaviour if they feel that it may affect the provision of much needed service.

Level of support

Table 1 indicates that, while 9 of the 18 clients received the level of support as recommended by the ICAP, the other 9 were under-supported. Most

strikingly, 4 of the clients who, according to the ICAP, should receive close supervision, lived in shelters or semi-independent living situations where supervision is infrequent.

Table 1. Comparison of Level of Support Recommended by the ICAP and Current Level of Support Received (figures on diagonal represent a match, figures below diagonal represent inadequate support)

Current Level of Support	*Level of Support Recommended by ICAP*		
	Close supervision	*Regular supervision*	*Infrequent supervision*
Close supervision (group/parent home)	6	0	0
Regular supervision (Habitat/boarding)	0	1	0
Infrequent supervision (SIL/shelter)	4	5	2

The most striking finding of this preliminary study is that 50% of clients with a dual diagnosis who were referred for a consultation service were under-supported in relation to their needs for supervision and assistance. This is not surprising given the recognition that dually diagnosed clients have been reported to have higher recommended levels of needs compared to general psychiatric population (Lunsky et al., 2003). This finding underscores a tension that exists in the community. Care providers often scramble to access mental health services at least in part because their client is under-supported and therefore his/her vulnerability is heightened. The mental health sector, on the other hand, is acutely aware of the paucity of resources in the community that would ensure a successful discharge from a psychiatric unit and the ensuing risk of prolonging the inpatient stay. This tension is sometimes sustained by defining the client's problem as "behavioural" or "psychiatric," thereby attempting to shift responsibility to the developmental or mental health sector.

A number of important areas of concern have been identified with the use of the ICAP. The presentation in individuals who are dually diagnosed is more complex than in those with developmental disability, particularly since impact of personality/psychiatric factors on performance of a skill is less consistent than when there is a only developmental failure to acquire it. It appears that the General Maladaptive Index may, in some cases,

underestimate the need for support if the very serious behaviour is very circumscribed or infrequent. In addition, the instrument is subject to respondent bias that may result in significant under- or over-rating. Given these concerns, caution is recommended when assessing individuals with a dual diagnosis.

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APPENDIX #6

State Resource Allocation Strategies and Challenges

Charles Moseley Ed.D,
National Association of State Directors of Developmental Disabilities Services
January 14, 2008
for
Maryland Developmental Disabilities Administration

Purpose and Intent

What do you want from your resource allocation / rate setting system?

- Improve ability to cover costs
- Implement uniform service payments
- Improve equity and fairness
- Address regional or historic inequities
- Link allocation amounts to service needs and the assessment process
- Support individualized budgeting

The Resource Allocation System *should…*

- Achieve state policy goals
  - ✓ Individual needs
  - ✓ Program / service direction and change
  - ✓ Provider capacity
- Align reimbursements with individual support needs, provider costs
- Be consistent and predictable
- Contain costs, document outcomes & promote sound fiscal management
- Achieve stability: minimize rate creep & cost escalation

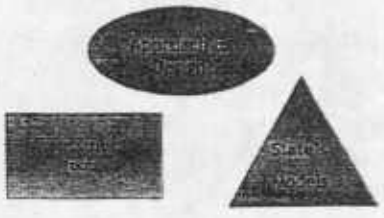
And…

- Reflect actual provider costs: services, management, operating, administration and overhead
  - ✓ Identify cost per units of service and by
  - ✓ Service type, scope, frequency & duration
- Reflect individual need
  - ✓ Individualized needs assessment
  - ✓ Person-centered planning
- Provide a framework for individual budgeting

Individual Budgeting Decision Framework

- *Who* will be served?
  - Eligibility
  - Funding priorities
- *What* services will be provided?
  - Identification of needs
  - Selection of supports
  - Service scope, limits and caps
- *How* much will be paid?
  - Assigning costs
  - Limits and caps
  - Establish funding methodology

Resource Allocation Strategies



Approach

Linking resource allocation amounts to individual need

- Individualized waiver services led to shifts in provider reimbursement methodologies
- Move from categorical, fee-for-service, program specific models to payments based on individuals' needs
- State strategies differ
- Developed uniform statewide systems for resource allocation

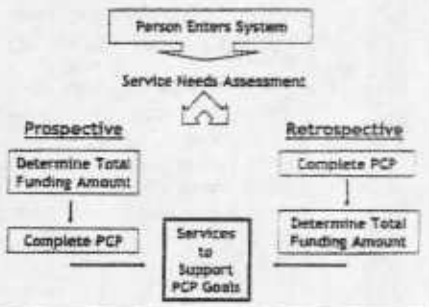
Needs Based Allocation Strategies

Two basic approaches:

1. Prospective - *Statistical*
2. Retrospective - *Developmental*

➡ Mixed

Prospective and Retrospective Budgeting Approaches



Prospective / Statistical

- Addresses the budgeting framework questions
- Methodology links individual assessment data to costs of services for individuals with similar needs
- Assessment based on data on functional characteristics and/or service needs.

Prospective....

- The budget amount is determined before the individual service planning process begins
- Process is data-based, must be transparent and available for consumer input.
- Wyoming's *DOORS*, South Dakota's *Service Based Rates*, Colorado

Retrospective / *Developmental*

- Provider payment allocations are set through a person-centered planning process
- Provider rates may be based on statewide tiers or a series of levels reflecting individual need differences
- Service amounts, numbers of hours are determined during the PCP process

Retrospective....

- Rates may be negotiated based on individual service need and statewide priorities.
- Payments typically reflect costs related to service provision, management, administration/overhead, operating, etc..

Assessment Tools

- Inventory for Client and Agency Planning (ICAP)
- Supports Intensity Scale (SIS)
- Developmental Disabilities Profile (DDP)
- North Carolina Supports Needs Assessment Scale (NC-SNAP)
- Maryland Individual Indicator Rating Scale

Assessment Issues to Consider

- *Scope* of assessment tool: national versus state-specific
- *Psychometrics* - Established reliability, validity and standardization
- *Comprehensiveness* - applied to all services and supports (MN in process) or *targeted* to specific waivers, populations or services
- *Administration methods*: independent, provider or state
- *Other issues* - stability, outlier coverage, gaming

ICAP

- Structured evaluation of adaptive and problem behaviors - 185 items
- Information on diagnosis, disability type, personal characteristics, functional limitations and service needs.
- Assist in screening, monitoring, managing and planning.
- Not designed for rate-setting and allocation but is used by some states for this purpose
- Used by: MT, WY, SD, TX, TN, IL, NE.

Using the ICAP*

Weaknesses

- Minimal health status information
- Minimally addresses support need
- Deficit based
- Inter-rater reliability
- Inadequate coverage of vocational supports
- No info on non-paid caregivers
- Does not support individual service planning

Supports Intensity Scale

- Measures frequency of support needs across life activity, behavioral and medical areas.
- Developed by AAIDD for adults
- Solid reliability and psychometrics
- Designed to assist individual support planning
- Subscales: home living, community living, lifelong learning, employment, health, safety, and social
- Does not gather some individual information
- States: UT, PA, GA, CO, WA, LA, OR, *...

Using the SIS*

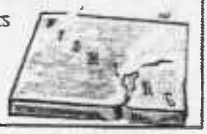
Weaknesses

- Best administered by skilled individuals
- Additional personal information must be provided
- Inter-rater reliability is less strong (but being improved)
- No child version

State Models

Wyoming - DOORS

- In existence since the mid 1990s
- ICAP to determine eligibility and functional status
- Sets individual rate using multiple regression techniques based on:
  - Individual characteristics
  - Historical expenditures
  - Service utilization



State Models *cont'd....*

Washington

- Payment model with information from the SIS and other consumer related factors including service hours and support levels.
- Determines direct support component of residential service rates
- Individual payment amounts across 7 levels
- In process - also working on payment models for employment supports, adult community access and others.

State Models *cont'd....*

Georgia

- Developed a statistical proprietary mechanism. Relates SIS assessment data to historical costs, current expenditures and annual funding allocations for the system at large
- Designed to achieve the fair and equitable allocation of resources statewide
- Rates will be based on a predetermined fee schedule
- Will support individual budgeting and self direction.

State Models *cont'd....*

Connecticut

- DDS Level Assessment. Currently used to set of level of need that is equated to a budget range.
- Identifies needs related to: medical/health, personal care, daily living, behavior/safety, communication, transportation, residential and day supports, social/recreational, unpaid caregivers and other factors
- Will establish budget levels by living arrangement type.
- Working to standardize provider rates
- Will apply to the state's two waiver programs

State Models *cont'd....*

South Dakota

- Sets individual allocation rates - individual budgets for the state's 19 provider agencies
- Uses a statistical regression formula to set individual rates based on: provider costs, individual service usage & ICAP
- Strong statistical model similar to Wyoming's DOORS methodology

Policy Issues

- Support allocations must be based on reliable cost and service utilization data
- The rate setting or individual budgeting methodology must be transparent, flexible, fair and equitable statewide
- Adequately cover the cost of services
- Permit the state to achieve its policy goals

More Policy Issues

- Permit individuals receiving support to achieve their own goals and aspirations
- Support self-direction
- Respond to outliers and unanticipated costs
- Minimize financial risk to individuals, providers and the state.
- Contain costs, ensure system stability

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APPENDIX #7

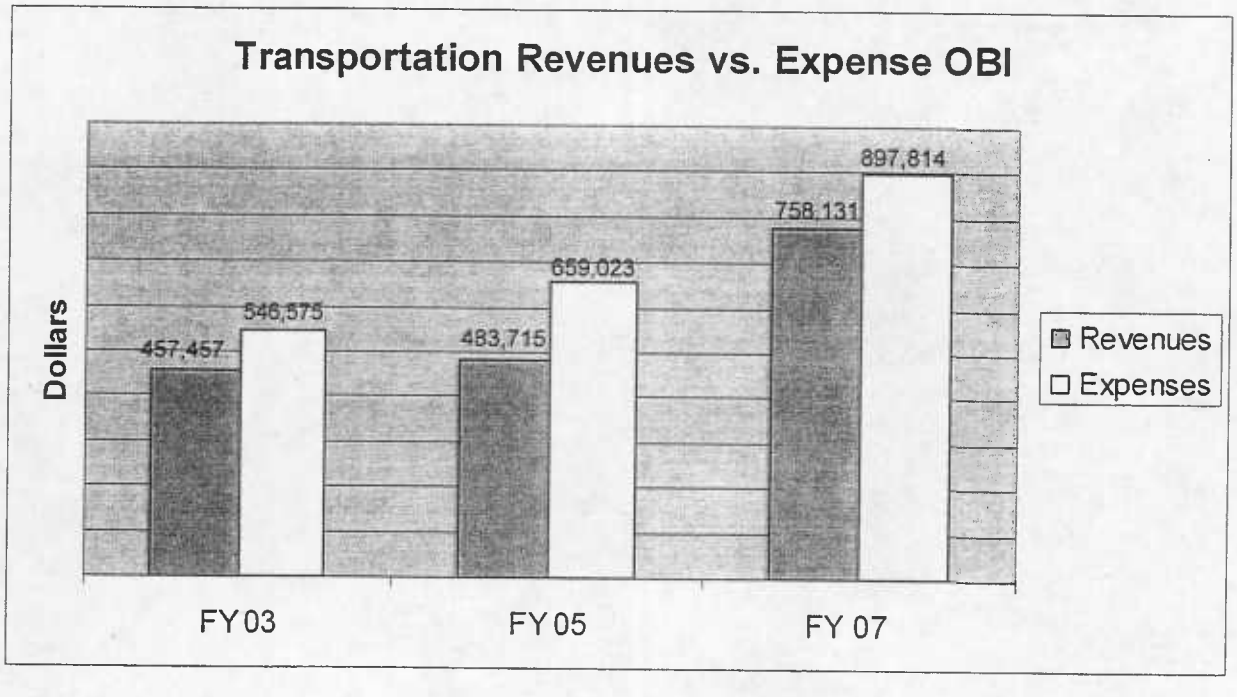
TESTIMONY
DDA Rate Payment Task Force
January 14, 2008

Transportation

I am Vicki Callahan, Executive Director of Opportunity Builders, Inc., a non profit vocational training agency in Anne Arundel County that serves approximately 310 individuals annually. We are currently running 31 van runs throughout Anne Arundel County and will approach 500,000 miles this fiscal year.

I am here to share my concerns about the ongoing deficits that we run in our transportation program. In FY 03 it was $89,118, then growing to $175,308 in FY 05. After a boost in the rates for transportation, FY 07 still resulted in a deficit of $139,683. With gas prices staying above $3.00 / gallon we anticipate FY 08 being no better.

Because transportation is essential to providing services this money is pulled from other revenues potentially effecting the quality of other services. It is imperative that rates increase to cover true transportation expenses, so that all other funding can be used to provide the quality services and supports all individuals deserve.



APPENDIX #8

Changes in Medication Administration/Board of Nursing Mandates for DDA-funded Providers

Year	Description	Additional Resources Required
1984	Medication training is 1 hour	
Approx. 1986	DDA-requires 16 hour training for all staff who will administer medications *(DDA provides trainings)*	• Additional 15 hours of direct support staff time to attend training
1998	Senate Bill 445 passes: • Creates new "registered Medication Assistant" under Board of Nursing • A Board of Nursing-mandated 16 hour class replaces DDA-required class; *(LPN can teach Unit 1 of medication administration training class); RN must teach Units 2 & 3)*	• Additional $10/per staff person for new registration fee • Additional 5 hours of LPN time *(for Unit 1)* • Additional 11 hours of RN time *(for Units 2 & 3)*
2004	New regulations promulgated governing "Delegation of Nursing Functions" • RN must perform 45 day reviews *(earlier regulations allowed LPN to do this review)*	• Additional $16-$20K per year to replace each LPN with an RN
2004 2006	Senate Bill 405 passes: Creating a new category of "Certified Medication Technician" (CMT) *(vs. previous "registered" status)* Regulations Implemented • New medication administration curriculum ("MTTP") is established • Initial $20 certification fee is set	• Additional one-time $20 per staff person

Year	Description	Additional Resources Required
	• Two year $30 certification renewal fee is set	• Additional bi-annual $30 per staff person
	• 4-hour clinical update is mandated as part of CMT re-certification	• Additional bi-annual 4 hours for every staff person • Additional bi-annual 4 hours for RN to perform update
	• MTTP course hours increases to 20 hours (from previous16 hours)	• Additional 4 hours for each direct support staff person in each class
	• Full MTTP course must be taught by an RN *(previously, an LPN could teach Unit 1 of the MTTP)*	• Additional 4 hours for each RN to teach each class, plus 5 hours for Unit 1 previously taught by LPN
	• Math and Reading competency test is instituted • 1:15 student:teacher ratio is mandated • 6 hour limit to training day is mandated	• Additional 1 hour of Human Resources staff time for each potential employee for test administration
	• New assessment by RN of "Clinical Competency" in medication administration in the clinical setting is added	• Additional (estimated) 2 hour visit by RN to clinical setting
	• RN must take 16 hour training class in order to teach MTTP course	• Additional 16 hours of RN time

APPENDIX #9

Chimes
Marty Lampner,
EVP and Chief Administrative Officer
410.358.4387 (office) 443.865.2322 (cell)
February 11, 2008

We thank the committee for the opportunity to address you today. One of issues that providers have faced since the inception of the FPS funding system and its predecessor, PPS which established the funding base still underlying today's, has been unfunded mandates.

Going back to the original funding system's enabling regulation one of the most glaring omissions was provision for direct Nursing Services. The early regulations contemplated an agency might have recoverable costs for nurses providing training to staff but the nurse was never conceived as a funded component of direct care to persons being served. In fact the regulations explicitly prohibited a provider doing so without first going to the department and getting approval and funding for the service a part from the rate.

10.22.03 05 D "Nursing services shall be preauthorized by the Administration, provided under the direction of a physician as required and recommended in the IPP, and include the following:

(1) Education, supervision, and training of staff and clients in health related matters;

(2) *Short term or intermittent services* (Adopted September 12,1986 and repealed July 26, 1999 and new chapter, General Provisions for Sanctions and Appeals was adopted)

Analysis of the original system indicates that the Health Medical Component was to provide for the costs associated with certain professional services and staff time associated with getting the person served to an appointment. It made no provision for nursing interventions, as we previously noted this was seen out of the scope of this system.

Over the years since 1987, the Board of Nursing has proposed many additional requirements on the provider community. It is important to note that like the nation at large the people we serve are part of the graying of America. Whatever disagreements the provider community might have with the specifics of the mandates that have come down over the years, there is no real question that needs of people with developmental disabilities in the community have escalated since the formulation of the original cost structure.

The required nursing services have expanded over the years; a list of many of these additions and changes is appended to this testimony. What has not expanded is the funding. Each new requirement has entered regulation preceded with the statement "no fiscal impact".

It is easy to see how that could be said. No one intervention is terribly expensive, a 45 day nursing assessment at Chimes taken as a single event costs $85.56 (Hourly rate $31 plus fringe of 20% with two hours for the assessment and 20 minutes for travel time).

If it were a one-time occurrence it truly would have little impact on a provider, but it is not. Forty-five day nursing assessments must be completed 8.11 times a year for a total of $690. Further the aging population served requires more medications so the number of individuals needing such assessments increases annually. For 100 individuals the cost is $69,000 annually. The need to perform the assessment in the individuals' home complicates this further and increases cost disproportionately for rural providers. When homes are widely scattered, as they are in Western Maryland or the Eastern Shore the cost is amplified by the time it takes to get the nurse on site.

Nursing Care Plans, again not something dreamed of back in 1987, may well be in the best interests of the people we serve, but again while no one plan costs much, $148 the number of times it must be done annually for a 100 people is $14,800.

Medication administration is a delegated task to the direct support professionals. The cost of providing the training including the time of the nurse and the direct support professional, paying the fees for the certification and the administrative time involved to coordinate and follow up this process is estimated to be $242 per staff person. The cost associated with an individual receiving service is dependent on the number of staffing hours assigned based on the matrix score. It can range from $49.86 for an individual with a level 1 in supervision, receiving 6.66 hours a week to $434.18 for an individual with a level 5 in supervision, receiving 58 hours a week. (See appendix for calculations) Using our hypothetical organization with 100 people being supported and an average matrix level of 4, the cost to the organization is $29,944.

Nurses have additional responsibilities including coordinating medical services, reviewing lab work, reviewing physician's orders and specialized training based on the needs of the person being served. Nurses also provide 24/7 on call availability on a rotating basis. Our experience indicates that the caseload of one nurse ranges from a low of 40 to 60 people with the complexity of the individual and the travel distance accounting for the variance. In our hypothetical organization serving 100 people, there would be two nurses with salaries of $64,480 and fringe of 20% for a total of $154,752 or $1,547 per person to provide nursing services. This $1,547 is funded out of general costs which are included in the ACG&T rate of the provider of $21,900 – 7.6% of the money that must provide insurance, food, housing, transportation, management, staff training human resource and financial services.

Without adequate funding, the people we serve are at risk. The providers and ultimately the system will not be able to meet new demands and will be pushed toward collapse. This is particularly disturbing as the system struggles to find new capacity to meet the challenge of the Rosewood Closure. Any review of the FPS system needs to acknowledge these costs and insure that future requirements are not added without funding.

Appendix

1. Administrative costs for medication administration training

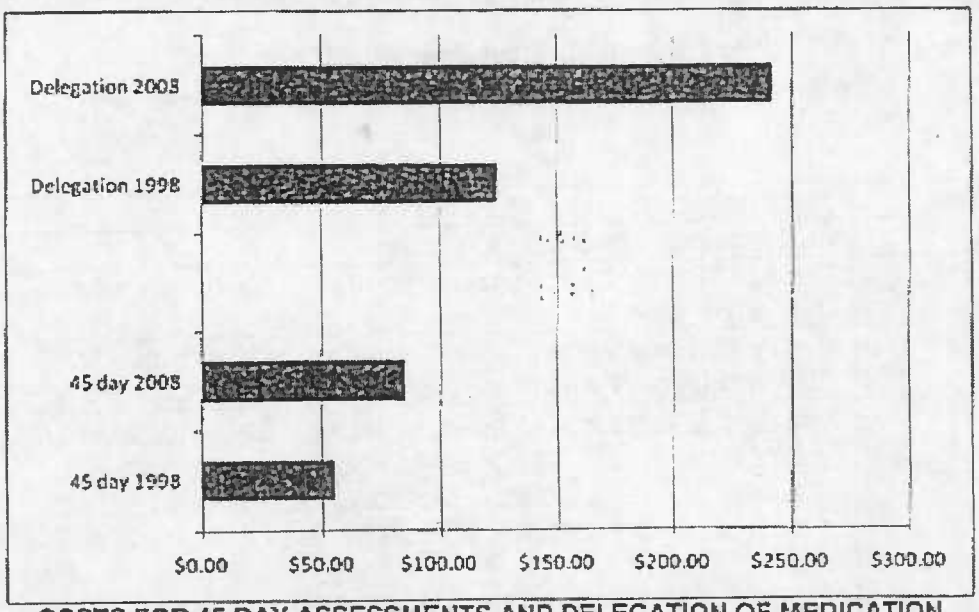
Staff Unit Cost Delegation Administration	
20 hours Training - DSP	$180.00
20 hours Training - RN - 15 students	$41.33
Registration Fee	$15.00
Clerical Support 0.5 hr/7.25	$6.00
	$242.33

Nursing hourly rate is
$31.00
DSP hourly rate is
$9.00
Supervision/Assistance

	1	2	3	4	5
Week	6.66	13.33	24	40	58
Annual hours	346.32	693.16	1248	2080	3016
FTE	0.17	0.34	0.62	1.03	1.49
T/O Factor 20%	0.205735	0.411778218	0.741386	1.2356436	1.7916832
1998 Delegation Unit cost	$49.86	$99.79	$179.66	$299.44	$434.18

2. 45 Day Assessments

Services	Unit cost	Freq/Annually	Total
45 day assessment - 2 hours	$62.00	8.11	$502.82
Travel time R/T 0.3 hrs	$9		72.99
Salary Cost	$71.30		$575.81
Fringe 20%	$14.26		$115.16
Total	$85.56		$690.97



COSTS FOR 45 DAY ASSESSMENTS AND DELEGATION OF MEDICATION ADMINISTRATION

45 day 1998	$55.20
45 day 2008	$85.56
Delegation 1998	$124.88
Delegation 2008	$242.33

Delegation costs have increased 94% and 45-day assessment costs have increased 55% over the past 10 years.

Board of Nursing Requirements for Services Funded by the Developmental Disabilities Administration

1984- 2007

Year	Description
1984	CMT training is one hour (R. Claxton)
1985	First MATP hours were 7(According to Barb Newman – meeting of 8/15/2005)
1986	Med Admin course was 16 hours –requirements were included in the DDA regulations for community services promulgated in 1986.
1989	*Med Admin course was 16 hours –First unit (7 or 8 hours) was taught by lay people and the second unit (7 or 8 hours) was taught by physicians. (Carter Center, Dr. George Lense and Dr. Barbara Hudson) The Developmental Disabilities Administration provided the training.* Nurse Practice Act promulgated (administrative history of Nurse Practice Act) G-tube feedings and other acts were not able to be delegated, every individual administered medication by paid staff needed a nursing care plan and were to be assessed every 45 days - assumptions had been made that DDA licensed services were not impacted by regulations) Very few DD providers served people with complex medical needs – this became an issue when Highland Health closed in July of 1989. Maryland's waiver was contingent on no private ICF-MRs.
1990 through 1992, there were multiple meetings among the Nursing Board, DDA, OHCQ and the provider community to define and clarify the requirements of the Board of Nursing in DDA licensed sites.	
1992 & 1994	Nurse Practice Act amended to allow g-tube feedings and other tasks that had not been able to be "delegated."
1998 - 2000	Health Occupation Article Title 8-6A-01 Law for Medication Assistant passed, 16 hour course and must register with the Board of Nursing and pay a $10.00. (BON website- Medicine Aides versus Medication Technicians) MATP – LPN can teach unit 1, RN must teach units 2 & 3 (DHMH 5.8.98, letter in DR file) Direct Support Professionals that have been performing delegated nursing functions such as G-Tube feedings, catheter care and respiratory therapy are eligible to be grandfathered in a Certified Nursing Assistants up to 2000 if the delegating nurse verifies the staff person has been performing those functions.
2002	According to a letter from Barbara Newman on January 15, 2002 – LPNs can work in a team relationship with an RN whom supervises the RN and and serve as the "delegating" nurse. The delegating nurse is responsible for those tasks outlined in the Nurse Practice Act, which includes a 45-day assessment when medication administration is delegated. The 45-day assessment includes assessing the individual, assessing the person that has been delegated to perform nursing tasks and assess the environment. The delegating nurse must observe the individual delegated to perform nursing tasks actually doing those tasks.
2003	On 6/13/2003, Barbara Newman stated during a provider meeting that

	the six hour refresher course and the six month review is DDA's requirement not the Board of Nursing. There is a requirement for a two year review across all practice areas covered by the Nurse Practice Act and the nurse should evaluate the individual whom is performing delegated tasks in the environment.
2004	Nurse Practice Act is revised to include functions of critical watching, if the RN assigns the LPN to fulfill the delegating nursing role, the RN must visit the environment every two weeks; medication technicians must be available on a continuing basis Certification of Medication Technician is instituted – an initial $20 fee with a two year renewal fee of $30. This will begin as a conversion process over two years with all current medication technicians' being converted and then renewed with the $30. The medication administration-training course was increased to 20 hours. Registered nurses had to complete the "Train the Trainer" Curriculum prior to being able to teach the course.
2006	New Certified Medication Technician Training Program is effective. Training includes 20 clock hours of classroom training, a maximum 6 hour training day, English and math proficiency exams not included in 20 clock hours, 1:15 instructor/student ratio, and clinical setting RN observation within 30 calendar days. Nurse Instructor must complete a 16 hour "train the trainer" in order to teach the course. A 4-hour clinical update is required to maintain CMT certification. Nurses serving as delegating nurses or case managers in DD licensed facilities must also complete a 16- hour course on delegation and case management. A quality assurance mechanism is required for delegation.

DDA Community Services
Funding Since 1999

Fiscal Year	Base	Inflation	Expansion	Wage	Total	Inflat/Wage	% Change Inflat/Wage	$ Change Total	% Change Total
FY99	278,929,464	0	27,913,164	0	306,842,628				
FY00	325,316,199	1,500,000	11,609,913	0	338,426,112	1,500,000	0.54%	31,583,484	10.29%
FY01	344,499,017	6,688,594	12,208,872	0	363,396,483	6,688,594	2.06%	24,970,371	7.38%
FY02	374,189,357	10,775,650	11,951,019	0	396,916,026	10,775,650	3.13%	33,519,543	9.22%
FY03	413,659,123	1,500,000	12,241,067	16,170,674	443,570,864	17,670,674	4.72%	46,654,838	11.75%
FY04	447,576,525	0	12,362,958	14,553,607	474,493,090	14,553,607	3.52%	30,922,226	6.97%
FY05	485,633,282	0	13,592,198	17,787,741	517,013,221	17,787,741	3.97%	42,520,131	8.96%
FY06	528,743,808	0	9,997,196	16,239,575	554,980,579	16,239,575	3.34%	37,967,358	7.34%
FY07	561,196,399	0	23,786,334	16,239,575	601,222,308	16,239,575	3.07%	46,241,729	8.33%
FY08	624,417,452	12,036,923	12,633,352	0	649,087,727	12,036,923	2.14%	47,865,419	7.96%

	Inflation/Wage	Expansion	Total	% Infl/Wage	% Expansion
FY99	0	27,913,164	27,913,164	0%	100%
FY00	1,500,000	11,609,913	13,109,913	11%	89%
FY01	6,688,594	12,208,872	18,897,466	35%	65%
FY02	10,775,650	11,951,019	22,726,669	47%	53%
FY03	17,670,674	12,241,067	29,911,741	59%	41%
FY04	14,553,607	12,362,958	26,916,565	54%	46%
FY05	17,787,741	13,592,198	31,379,939	57%	43%
FY06	16,239,575	9,997,196	26,236,771	62%	38%
FY07	16,239,575	23,786,334	40,025,909	41%	59%
FY08	12,036,923	12,633,352	24,670,275	49%	51%
Average	11,349,234	14,829,607	26,178,841	43%	57%

APPENDIX #10

DDA Community Services
Overall Rate Increases by Fiscal Year

	Total Cost	Cost Change	Avg Rate	% Change
Residential				
FY01	230,325,538		122.82	
FY02	237,332,848	7,007,310	126.55	3.04%
FY03	250,156,108	12,823,260	133.39	5.40%
FY04	258,893,383	8,737,275	138.05	3.49%
FY05	268,597,123	9,703,740	143.22	3.75%
FY06	278,110,458	9,513,334	148.30	3.54%
FY07	288,275,843	10,165,385	153.72	3.66%
FY08	293,676,909	5,401,066	156.60	1.87%
Day & S/E				
FY01	116,344,422		46.53	
FY02	118,785,224	2,440,802	47.50	2.10%
FY03	123,704,714	4,919,489	49.47	4.14%
FY04	126,724,960	3,020,247	50.68	2.44%
FY05	130,714,356	3,989,396	52.27	3.15%
FY06	134,837,826	4,123,470	53.92	3.15%
FY07	139,415,714	4,577,888	55.75	3.40%
FY08	143,466,732	4,051,017	57.37	2.91%
Add-On				
FY02	78,383,443		13.45	
FY03	84,265,061	5,881,618	14.46	7.50%
FY04	87,431,641	3,166,580	15.00	3.76%
FY05	91,423,770	3,992,129	15.69	4.57%
FY06	95,258,498	3,834,728	16.35	4.19%
FY07	99,172,812	3,914,314	17.02	4.11%
FY08	99,816,873	644,061	17.13	0.65%

DHMH
DDA
Funding Since 1999

	FY99	FY00	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08
Base	278,929,464	325,316,199	344,499,017	374,189,357	413,659,123	447,576,525	485,633,282	528,743,808	561,196,399	624,417,452
TY	2,849,151	2,500,000	2,500,000	2,684,581	2,503,588	5,259,180	6,790,918	7,010,009	7,689,300	7,560,176
Emergency	4,978,868	3,126,257	2,611,983	2,191,805	1,441,011	3,116,881	5,055,808	2,023,958	2,698,691	3,119,871
WL	19,835,145	5,093,818	4,354,863	4,518,595	4,651,928	2,139,261	0	0	10,000,000	0
DI			1,321,500	1,105,152	2,275,041	1,347,636	1,045,472	0		0
WLEF	250,000	889,838	1,420,526	1,450,886	1,369,499	500,000	700,000	963,229	1,231,157	1,953,305
Written Plan									412,800	
Rate Enhancement		1,500,000	1,500,000	1,500,000	1,500,000					
Inflation			5,188,594	9,275,650						12,036,923
Wage Initiative					16,170,674	14,553,607	17,787,741	16,239,575	16,239,575	
Transportation									1,754,386	
	306,842,628	338,426,112	363,396,483	396,916,026	443,570,864	474,493,090	517,013,221	554,980,579	601,222,308	649,087,727

APPENDIX #11

DDA Rate Setting Task Force

Making the Case for Increasing Rates for Employment Supports

1. DDA Mission

The mission of the Developmental Disabilities Administration is to provide leadership to assure the full participation of individuals with developmental disabilities and their families in all aspects of community life. In addition, DDA's goal is to promote their empowerment to access quality supports and services necessary to foster personal growth, independence and productivity.

2. Funding of Employment Services

Maryland has 2 funding streams for employment services:

1) Vocational & Day Services

Teaching skills for daily living (Day Habilitation)

Teaching skills necessary to enter the workforce (Day Vocational)

Adult Day Care

Providing support to individuals which allow them to work successfully in the community (Supported Employment). This can include volunteer work.

2) Supported Employment

These are community-based services that provide the supports necessary for individuals to obtain and maintain work in the community. Supports may include job skills training, job development, vocational assessment, and ongoing job coaching support. This does not include job development.

3. Perspectives from People with Developmental Disabilities

Ask Me! is a Consumer Quality of Life Evaluation administered by The Arc of Maryland for the Developmental Disabilities Administration. The *Ask Me! Survey* collects information from people receiving supports funded by the DDA to determine their satisfaction with the quality of their lives. Over the past 6 years, an average of 55% of the respondents reported that they are getting training to help them get a job. An average of 60% of respondents said that they chose their jobs or what they do most days. 57% reported having the chance to earn good money.

4. Systems Issues in Maryland

a. day/vocational and supported employment have the same rate
b. supported employment typically costs more – lower staff/consumer ratio; transportation

c. no incentive to providers to provide employment services; administrative burden
d. for providers to receive the supported employment rate, a person has to work at least 4 hours day, not including commuting time; as a result, providers are moving the people they support into the day/vocational funding stream
e. the percentage of people in day vs. community employment has not changed significantly over time
f. no accurate statewide number of people who are working in integrated work settings, or other outcome data, is available

5. What Research Tells Us about Employment and Rate Setting

States that have done well in the area of community employment have:

- established individual reimbursement rates for the various day and vocational services and increased rates for community employment (Tennessee, Colorado, Florida) – this encourages providers to shift toward community employment
- earmarked specific portions of their match dollars for specific day and vocational services, increased match allocations for community employment (Maine and Oklahoma), and reduced match allocations for segregated work and non-work services[1]

6. Possible Solutions

1. Increase supported employment rate
2. Increase supported employment rate by reducing rate for day habilitation
3. Fund providers based on performance
4. Design and implement a system to measure employment outcomes
5. Consider the Supports Intensity Scale (AAIDD) – the rating system looks at the supports a person needs to be successful

Prepared by Cathy Lyle
Maryland Developmental Disabilities Council
March 10, 2008

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[1] Mills, Lisa A. "Revitalizing Integrated Employment: A Study of Nationwide Best Practices for Increasing Integrated Employment Outcomes Among People with Developmental Disabilities." Dec. 2006. A study funded by the Centers for Medicare and Medicaid Services, Medicaid Infrastructure Grant, Wisconsin Dept. of Health and Family Services

APPENDIX #12

Task Force to Study the DDA Rate Payment Systems

Testimony regarding Supported Employment

Five-Seven Days---Ian to provide Karen

Issues

1. DDA currently only pays for a "day of supported employment" if the individual is working or volunteering 4 hours a day.

2. Job development, Social Networking, travel training, and development of a small business are currently not reimbursed under DDA's FPS unless they are done during the while a person is working.

3. People with the most significant disabilities often lack the stamina to work 4 hours a day and are therefore not able to participate in Supported Employment.

4. Employers often want to start off a new employee with an abbreviated schedule of 1-2 hours per shift, 1-2 days a week.

Background

Current DDA Supported Employment Program Regulations 10.22.07.03 (c) are reflective of what is considered best practices according to the Association of Persons in Supported Employment (APSE). As defined in COMAR, those services include but are not limited to....Self employment, job skills training, community mobility training, guidance in acceptable job behaviors, job seeking and interview skills, training in social skills and money management.

Inconsistently, the Fee Payment Regulations, 10:22.17.02 state ...Supported Employment is, when the individual is engaged in supported employment for at least 4 hours a day, with 6 to 8 hours per day as the service goal, and with Administration approval of fewer than 6 hours per day provided the individual plan indicates this lower level of service is necessary.

DDA's rate system has interpreted this regulation to mean that Supported Employment reimbursement will only be made on days when a person being supported is working for 4 hours a day.

Solution

DDA should pay for supported employment services if any of the services or combination of services defined in 10.22.07.03 are provided for 4 hours per day.

The 5/7ths Funding Issue

Issue:

DDA Supported Employment and Day Habilitation provider' calculate support's by using a 5 day week 4-8 hours per day base for supports. DDA then divides the day habilitation days by 7.

Background

Both the Day Habilitation and Supported Employment Program funding methods are calculated using similar premises and constructs. Funding is determined by the Matrix Level established for Health/Medical and Supervision/Assistance required. The resulting funding as expressed in the DDA matrix establishes the number of hours of supports an individual is deemed to need during the course of a week. DDA also determines a "direct care gross hourly rate" – for FY 2007 that rate was $9.13 per hour. DDA then multiplies the hourly rate ($9.13 per hour) times the number of supported hours (e.g. a matrix level of 1.1 would yield 5 hours of expected support).

In this example, DDA would multiply $9.13 per hour x 5 hours which results in $45.65 per week. An allocation for employer fringe and benefits is then added to this number (the FY '07 rate was 27.2%). Accordingly, in our example, an agency would expect $58.07 per week in funding. DDA then divides this weekly funding by seven (7) days to obtain a per diem rate - in our instance, $8.30 per day.

However, this system was built upon the premise that individuals would need to work seven (7) days per week to obtain the *fully funded* and budgeted allocation. In reality, most community providers are able to support individuals with disabilities at a place of work for five (5) days per week. This is commonly referred to as the "5/7ths funding issue."

Consistent with our example, although budgeted for $58.07 per week, a community provider is only likely to recoup $41.50 per week. Correspondingly, DDA's expectation, consistent with the matrix level noted in our example is that a provider should be supporting an individual for five (5) hours per week; however, they are only being paid for 3.57 hours per week.

This gives rise to two (2) questions:

Why is the Supported Employment funding system and budgeting built upon seven day work week instead of a five day work week? and

Where does the remaining 28% (the uncollectible 2/7^{ths}) of the Supported Employment (and Day Habilitation) budget that cannot be collected go?

Solution:

If DDA should use a 5 day a week model for Day and Supported Employment supports.

APPENDIX #13

Michael Bloom

I use self direction on the New Directions Waiver. It feels good to be in control of my life. I feel extremely powerful. Self Direction makes me feel independent and free.

I was in 2 group homes. Self Direction is better, because in group homes I had no choice where I lived or who I lived with or the staff. Now I have those choices.

I pick my staff, we advertise for them, interview them. I train them and if I don't like them I fire them. I have very good relationships with staff they work well with me. They take me places, and help me stay active walking and having fun. It's good to be the boss of my staff.

My staff helps me find jobs so I don't go to day programs at all anymore. I work on Community Connections and get paid. Now as an advocate I talk to other people about the New Directions Waiver and about what it means to use New Directions.

I am in charge of my budget, it is the best thing that ever happened to me. I am able to have my own place. In group homes I did not know anything about my budget. Now I sign paychecks, I sign for things we purchase for the house. Medsource cuts my payroll checks and pays my other bills as I tell them too.

I can go back to school if I want, I never had that chance under my other services. I was not a happy person in group homes.

I feel free and good now.

APPENDIX #14

CSLA Funding; Recommended Changes

We have four concerns about how funding for CSLA services are working. We think the basic structure of the CSLA payment system is worth preserving if these concerns can be addressed.

Hours

The basic structure of CSLA funding is that the Individual's team makes a decision about the number of hours of service the Individual should receive and they request those hours from DDA. The fewer hours of service the higher the hourly rate. The rate goes down for each additional person the Individual is living with. A maximum of three clients can live together.

Concern #1;

This model assumes that if people are living together there are efficiencies because of overlap hours. DDA has been inconsistent in how it interprets overlap hours. In order for the system to be financially viable overlap hours need to be allowed. In other words if one counselor is working with two clients in their apartment for two hours, then this creates four billable or countable hours. DDA need clear and consistent guidelines for this.

Concern # 2:

DDA has recently begun auditing providers to make sure that they are indeed delivering all of the hours of service that they are funded for. Through a third party a sample group of Individuals are selected and audited. They look at a six month period and whether the average number of hours is being delivered. If they are not being delivered then there is a financial disallowance.

This approach is not consistent with one of the tenets of the CSLA model, which is to be flexible enough to meet the changing needs of an individual receiving supports. This lack of flexibility is also not financially viable for providers, and it does not necessarily serve the service recipients. Service providers typically will over serve some clients and under serve other clients at any given time. Clients needs and circumstance change with some regularity.

Service providers do not gain money if they are caught over-serving someone, they only lose money when someone is under-served. Service providers are told to change the service funding plan when the needs of the client change. However the experience of service providers is that DDA is always willing to process a reduction, but often unwilling to process an increase.

For CSLA to work financially, providers must be able to manage a "risk pool" of funding, because of the changing needs of the individuals receiving CSLA services. Service providers are in a much better position to manage this "risk pool" if you will, than DDA is. It also typically takes 3-4 months to process such a change and at considerable administrative cost for both the provider and the State.

We believe that as long as the service provider is delivering the *total* number of hours of service they are funded for (for all individuals) or within 5%, then there should be no disallowance or if there is a disallowance the tolerance should be more like 50% of the hours being delivered per person. This would give providers the flexibility needed to meet individuals' needs, while still maintaining accountability for the overall funding provided by DDA.

The Individual has many avenues of accountability. They can change providers, they have a Resource Coordinator to monitor the implementation of their plan and they often have family who are strong advocates.

Concern # 3, Housing:

The CLSA funding model is that individuals live in houses or apartments that they own or rent themselves. They pay no fee to the provider or the State and instead they pay their own rent, utilities, food etc. Individuals live in a variety types of homes. Some Individuals can afford this arrangement, some Individuals are able to access Housing Choice vouchers or other public housing subsidies but many can not afford these costs. Individuals are many times choosing a group home option because of the cost of housing.

DDA does allow the cost of housing to be built into budgets, but there is not a consistent approach to this. DDA needs to develop a consistent approach to addressing the cost of housing that recognizes the realities of the cost of housing and the situation of each Individual. We would suggest using HUD guidelines.

Concern # 5, Nursing:

Many of the Individuals served in CSLA are required to have nursing services, most often for medication administration but also for other medical issues. Service providers are required to meet DDA and Maryland Board of Nursing regulations. The current professional rate, $26 to $27.84, does not pay for the cost of nursing in Maryland. This rate needs to be increased to recognize actual costs.

Tim Wiens, Jubilee Association of Maryland & Rick Callahan, The Arc of Central Chesapeake Region and both of us in collaboration with MACS

APPENDIX #15

Comparison of FPS rates using DDA's hourly rate and the Rate Commission's rate

The attached charts demonstrate part of the problem that exists with rates paid by the DDA and the actual costs incurred by community providers.

There are two pages; one for the Residential matrix and one for the Day matrix. Each is for the Individual Component of the rate, specifically the Supervision/Assistance portion. The Health/Medical portion is not addressed here because it is not as sensitive to labor costs, and is a smaller part of the overall rate.

Upper Box

1) Shows what DDA is paying providers for Fiscal 2008. The bottom line shows the *Daily Rate* of reimbursement for each level of supervision, one through five.
2) The hourly rate used to drive the *Daily Rate* is $9.12 for Residential and $9.13 for Day.

Middle Box

1) Shows the average rate that was paid in the community for Fiscal 2007, based on preliminary data generated by the Community Services Reimbursement Rate Commission (CSRRC).
2) The average rate paid is $11.33 per hour for both Residential and Day.

Lower Box

1) Shows the variance between the amounts reimbursed by DDA and the amounts paid by the provider community for each matrix level. Both a daily figure and annualized figure is shown.
2) The third line, *Provider Actual Weekly Hours Covered by FPS Rate*, shows the number of hours actually paid for by the State, using the average hourly rate paid in the community. For level one of the Residential matrix the calculation is:
   $60.80 divided by $11.33/hour, which equals 5.37 hours
3) The fourth line shows the variance each week between the number of hours that the State actually pays for, and the amount the State assumes is actually provided in the community.

Conclusions/Issues:

1) Note that the average wage paid in the community is driven by all of the wages in the community, including those paid through Add-on services. Add-on services are, in fact, reimbursed at a rate that is higher than $9.12 or $9.13, so the analysis overstates the variance to some degree. However, the bulk of the payments by DDA are through the FPS, so the variances are still very important. Additionally, the data compares 2008 rates paid with 2007 costs incurred, with understates the variance.
2) Note that the Day Matrix figures account for no Leave (Vacation or Sick), Vacancy, or Holiday/Snow Days for employees. The assumption of 100%

attendance by employees is not realistic. Community providers typically cover these absences with substitute staff, often paying overtime.

3) The weekly hour variance is an important issue for Add-on services because DDA uses the higher figure as the number of hours assumed to be delivered through the FPS rate. When calculating the number of hours to pay for add-on services, DDA deducts the assumed figure from the number required and then reimburses based on that calculation. By using the higher number of hours, fewer hours are then paid for as Add-ons. It is interesting to note that the DDA acknowledges the higher pay rate in the community by paying at a higher rate for Add-ons, but doesn't use this higher rate when calculating the assumed number of hours included in the FPS rate.

DDA PAYMENT STRUCTURE

FY 08

DAY MATRIX

SUPERVISION/ ASSISTANCE

	1	2	3	4	5
DDA DIRECT CARE HOURLY PAY RATE USED IN CALCULATION	$9.13				
WEEKLY HOURS PER CONSUMER AS DEFINED BY DDA	5	6.6666667	10	13.333333	20
WEEKLY HOURS X DDA RATE	$45.65	$60.87	$91.30	$121.73	$182.60
DDA PERCENTAGES APPLIED					
FRINGE (27.2%)	$12.42	$16.56	$24.83	$33.11	$49.67
SUBTOTAL	$58.07	$77.42	$116.13	$154.84	$232.27
LEAVE					
VACANCY					
HOLIDAYS/SNOW DAYS					
TOTAL WEEKLY RATE	$58.07	$77.42	$116.13	$154.84	$232.27
DAILY RATE (WEEKLY RATE /7)	$8.30	$11.06	$16.59	$22.12	$33.18

PROVIDER AVERAGE ACTUAL COST

BASED ON FY 07 DATA

DAY MATRIX

SUPERVISION/ ASSISTANCE

	1	2	3	4	5
AVERAGE ACTUAL PROVIDER DIRECT CARE HOURLY PAY RATE (rate as reported in draft CSRRC report)	$11.33				
WEEKLY HOURS PER CONSUMER AS DEFINED BY DDA	5	6.6666667	10	13.333333	20
WEEKLY HOURS X DDA RATE	$56.65	$75.53	$113.30	$151.07	$226.60
DDA PERCENTAGES APPLIED					
FRINGE (27.2%)	$15.41	$20.55	$30.82	$41.09	$61.64
SUBTOTAL	$72.06	$96.08	$144.12	$192.16	$288.24
LEAVE					
VACANCY					
HOLIDAYS/SNOW DAYS					
TOTAL WEEKLY RATE	$72.06	$96.08	$144.12	$192.16	$288.24
DAILY RATE (WEEKLY RATE /7)	$10.29	$13.73	$20.59	$27.45	$41.18

VARIANCES

DAY MATRIX

SUPERVISION/ ASSISTANCE

	1	2	3	4	5
DAILY RATE VARIANCE	($2.00)	($2.67)	($4.00)	($5.33)	($8.00)
% VARIANCE	-24.1%	-24.1%	-24.1%	-24.1%	-24.1%
ANNUAL DOLLAR VARIANCE DUE TO RATE	($498)	($664)	($995)	($1,327)	($1,991)
PROVIDER ACTUAL WEEKLY HOURS COVERED BY FPS RATE	4.03	5.37	8.06	10.74	16.12
WEEKLY HOUR VARIANCE	(0.97)	(1.29)	(1.94)	(2.59)	(3.88)

DDA PAYMENT STRUCTURE

FY 08

RESIDENTIAL MATRIX

SUPERVISION/ ASSISTANCE

	1	2	3	4	5
DDA DIRECT CARE HOURLY PAY RATE USED IN CALCULATION $9.12					
WEEKLY HOURS PER CONSUMER AS DEFINED BY DDA	6.6667	13.3333	24	40	58
WEEKLY HOURS X DDA RATE	$60.80	$121.60	$218.88	$364.80	$528.96
DDA PERCENTAGES APPLIED					
FRINGE (26.21%)	$15.94	$31.87	$57.37	$95.61	$138.64
SUBTOTAL	$76.74	$153.47	$276.25	$460.41	$667.60
LEAVE (7.35%)	$5.64	$11.28	$20.30	$33.84	$49.07
VACANCY (9.99%)	$7.67	$15.33	$27.60	$46.00	$66.69
HOLIDAYS/SNOW DAYS (4.29%)	$3.29	$6.58	$11.85	$19.75	$28.64
TOTAL WEEKLY RATE	$93.33	$186.67	$336.00	$560.00	$812.00
DAILY RATE (WEEKLY RATE / 7)	$13.33	$26.67	$48.00	$80.00	$116.00

PROVIDER AVERAGE ACTUAL COST

BASED ON FY 07 DATA

RESIDENTIAL MATRIX

SUPERVISION/ ASSISTANCE

	1	2	3	4	5
AVERAGE ACTUAL PROVIDER DIRECT CARE HOURLY PAY RATE $11.33 (rate as reported in draft CSRRC report)					
WEEKLY HOURS PER CONSUMER AS DEFINED BY DDA	6.6667	13.3333	24	40	58
WEEKLY HOURS X DDA RATE	$75.53	$151.07	$271.92	$453.20	$657.14
DDA PERCENTAGES APPLIED					
FRINGE (26.21%)	$19.80	$39.59	$71.27	$118.78	$172.24
SUBTOTAL	$95.33	$190.66	$343.19	$571.98	$829.38
LEAVE (7.35%)	$7.01	$14.01	$25.22	$42.04	$60.96
VACANCY (9.99%)	$9.52	$19.05	$34.28	$57.14	$82.85
HOLIDAYS/SNOW DAYS (4.29%)	$4.09	$8.18	$14.72	$24.54	$35.58
TOTAL WEEKLY RATE	$115.95	$231.90	$417.42	$695.70	$1,008.77
DAILY RATE (WEEKLY RATE / 7)	$16.56	$33.13	$59.63	$99.39	$144.11

VARIANCES

RESIDENTIAL MATRIX

SUPERVISION/ ASSISTANCE

	1	2	3	4	5
DAILY RATE VARIANCE	($3.23)	($6.46)	($11.63)	($19.39)	($28.11)
% VARIANCE	-24.2%	-24.2%	-24.2%	-24.2%	-24.2%
ANNUAL DOLLAR VARIANCE DUE TO RATE	($1,179)	($2,359)	($4,246)	($7,076)	($10,260)
PROVIDER ACTUAL WEEKLY HOURS COVERED BY FPS RATE	5.37	10.73	19.32	32.20	46.69
WEEKLY HOUR VARIANCE	(1.30)	(2.60)	(4.68)	(7.80)	(11.31)

APPENDIX #16

Somerset Community Services
FY 08 ONE TO ONE ANALYSIS

Pay for 30 hrs but provide 50 hrs
assumes level 5 includes 20 hrs of support

FY 08 Day Program Rate

REVENUE

	Rate for 5x5	Days	Annual
Consumer	48.77	240	11,705
Admin	30.49	240	7,318
Total			19,022

Add on Rate	Hours/wk	Week	Day	Annual
16.19	30	485.70	97.14	23,314

Total direct care reinbursement for one to one consumer getting 30 add on hours at 5/5 rate
35,018

EXPENSE

Total Costs to Hire a One to One Staff for 50 hours (1-1 for day and transportation)

30,888	annual salary for 50 hours per week at $10.80/hour
4,400.00	health insurance
2,362.93	fica
617.76	UI 2%
926.64	WC 3%
1,544.40	Pension 5%
40,739.73	Total

(5,721.33) Net of revenue less expenses for one to one day staff

APPENDIX #17

TESTIMONY
DDA Rate Payment Task Force
April 16, 2008

Day 1:1 Add On
Funding Shortfall

I am Vicki Callahan, Executive Director of Opportunity Builders, Inc., a non profit vocational training agency in Anne Arundel County that serves approximately 310 individuals annually. We are currently serving 14 individuals with significant medical or behavioral needs with Add – On for 1:1 supports.

I am here to share my concerns about the funding shortfalls that we experience when we serve an individual with a 40 hour 1:1 add on. The attached spreadsheets show the costs to OBI for a entry level 1:1 and an employee who has completed 3 yeas of service. As you can see the shortfall is substantial. This shortfall in funding then forces us to use other funds to cover this shortfall potentially affecting the quality of other services.

It is imperative that this funding issue be addressed to cover true expenses, so that all other funding can be used to provide the quality services and supports all individuals deserve.

Fundng Issue for Day Service 1:1

Employee Entry Level	$ 23,295.00		
FICA	$ 1,782.07		
WC/UE	$ 698.85		
Pension (0 - 3 years) 2%	$ 465.90		
Health/Dental	$ 4,560.00	**Benefit**	**OBI Benefit**
Life / Disability	$ 480.00	**Totals**	**Percentage**
Legal Services	$ 120.00	$ 8,106.82	35%

DDA FUNDING FOR SALARY		$ 18,970.00
DDA FUNDING FOR BENEFITS	26%	$ 5,138.00
OBI SALARY SHORTFALL		$ 4,325.00
OBI BENEFIT SHORTFALL		$ 2,968.82
OBI TOTAL LOSS		$ 7,293.82

Employee 3 yr Level	$ 24,273.00		
FICA	$ 1,856.88		
WC/UE	$ 728.19		
Pension (3 - 9 years) 4%	$ 970.92		
Health/Dental	$ 4,560.00	**Benefit**	**OBI Benefit**
Life / Disability	$ 480.00	**Totals**	**Percentage**
Legal Services	$ 120.00	$ 8,715.99	36%

DDA FUNDING FOR SALARY		$ 18,970.00
DDA FUNDING FOR BENEFITS	26%	$ 5,138.00
OBI SALARY SHORTFALL		$ 5,303.00
OBI BENEFIT SHORTFALL		$ 3,577.99
OBI TOTAL LOSS		$ 8,880.99

Analyses of FY 2007 DDA Cost Reports

5 May 2008 DRAFT – Not approved by the Commission

Executive Summary

Providers appear to be consistently incurring losses on day and supported employment programs. These losses may be due to increased transportation costs. Residential services generally operated at a slim positive margin in 2003 and 2006, and a slim negative margin in 2004, 2005 and 2007. Community Supported Living Arrangements (CSLA) services were generally profitable in 2007, as was the case in prior years. It should be noted that these results are in aggregate, and that individual providers may be losing money on a service when the aggregate result is a profit, and vice versa.

Introduction

The CSRRC is required by its enabling legislation to:

> Review the data reported in the Developmental Disabilities Administration Annual Cost Reports and use the data to develop relative performance measures of providers.

To this end 111 Cost Reports for fiscal year 2007 were obtained from the Developmental Disabilities Administration (DDA), key fields from these cost reports were extracted and input into a database for analysis, and the analysis described in this report was then carried out.

To avoid any misunderstanding it will be worthwhile to discuss how the term "relative performance measures" is being interpreted for this purpose. The cost reports provide data on costs, revenues and utilization, so the performance measures that can be generated using the Cost Reports are necessarily financial and utilization measures. Accordingly, the measures that result are comparisons of providers with one another. As such they do not represent comparison with some objective standard. It will not be possible to develop outcomes measures from these data.

Questions to be addressed

Some specific questions will be addressed by this analysis. The first item will be to provide some general descriptive information regarding the range of services provided. The second will be the relative profitability of the different types of services provided, i.e., day services, residential services, employment services, and CSLA, in total and by provider. The FPS includes two components to rates: a client component that varies depending upon client needs, and an administrative component that is a fixed amount per day for the particular service. In response to the directive to study transportation costs the transportation costs and mileages will be studied.

Analysis and results

Descriptive statistics

The following table presents some summary statistics from the Cost Reports. In this table medians are presented rather than means as they are less influenced by outliers.

Table 1: Summary statistics, fiscal year 2007

	CSLA	Residential	Day	Employment
# of providers	64	86	60	63
Median Margin 2006	9.33%	0.54%	-0.20%	-5.20%
Median Margin 2007	7.65%	-0.97%	-2.67%	-4.43%
Median Cost/Day	$77.71	$204.40	$77.42	$66.51
Percentage of revenue	9%	61%	19%	11%

These data suggest that providers are profiting from the provision of CSLA services, and are generally losing money on supported employment services. These results are generally consistent with the results found for fiscal years 2002 through 2006. CSLA services were implemented relatively recently, and recently enrolled clients are reported to be more profitable than clients who have been with a provider for an extended period of time. The payments for CSLA comprise only about 10% of the total expenditures on community services.

Transportation costs

The FY 2003 Cost Report was the first in which detailed data on transportation costs and utilization were collected. These data were examined and large differences among providers in transportation costs were noted. However, due to problems with the data reported the analysis of transportation costs was delayed. The quality of the transportation data did appear to be somewhat improved in the FY 2004 Cost Reports, although there were still some obvious problems. The survey forms and instructions were substantially revised for the FY 2005 survey to reduce any ambiguity as to what should be reported. The FY 2007 Cost Report used the same forms as the FY 2005 and 2006 Cost Reports. While the data have improved over time, there are clearly inconsistencies in the ways in which the transportation cost data are being reported, so the results presented below should be interpreted with caution.

The following tables provide summaries of the transportation costs per day and per mile.

Table 2: Transportation cost per client per day

	Day	Supported Employment	CSLA	Residential
Median FY 2006	$11.99	$8.94	$2.92	$6.77
Median FY 2007	$11.85	$9.11	$3.51	$7.09

Table 3: Transportation cost per mile

	Day	Supported Employment	CSLA	Residential
Median FY 2006	$1.58	$1.02	$0.72	$0.61
Median FY 2007	$1.71	$0.92	$0.72	$0.73

Caveats and comments

Transportation costs are a major issue for day and supported employment services. For residential services providers the transportation requirements are smaller, and more varied in their nature, with transportation of residential clients to day programs generally being provided by the day program.

The data still show substantial variation between providers in the costs. By reporting medians the impact of these variations is reduced, but not eliminated.

The capital cost for vehicles is based on depreciation. This underestimates the real cost in that it does not account for inflation. Also, many providers are likely to have vehicles that are fully depreciated so are not contributing any depreciation cost.

Conclusions

Providers appear to be incurring losses on day and employment programs. These losses may be due to increased transportation costs. Residential services operated at a slim positive margin in 2003 and 2006, and a slim negative margin in 2004, 2005 and 2007. CSLA services were generally profitable. Even in services in which the median margin is positive there are still a substantial number of providers with negative margins, and conversely for services in which the median margin is negative.

C:\myfiles\csrrc_fy2008\Cost_report_2007.doc

APPENDIX #19

C·H·I Centers Inc.

Supporting people with disabilities since 1948

Kenneth S. Savell, Esq.
President

Alan Lovell, Ph.D.
Chief Executive Officer

April 23, 2008

Mr. Jim Johnson, Deputy Secretary
for Operations
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201

Dear Jim:

I would like the Department of Health and Mental Hygiene to support the language in the current solutions of the Developmental Disabilities Administration Wage Task Force.

I would like for bullet two to reflect the following:

> "There should be equitable rates based on recommended geographical or programmatic differences to reflect costs approved by the Developmental Disabilities Administration."

Sincerely,

Alan C. Lovell
Chief Executive Officer

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The Rehabilitation Accreditation Commission (CARF)
United Way Agency #8059
Combined Federal Campaign #27098

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